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105 Ohio St.3d 30, 821 N.E.2d 1008, 2004-Ohio-7114

Briefs and Other Related Documents

Supreme Court of Ohio.
In re GUARDIANSHIP OF STEIN.
No. 2004-0928.
Submitted Oct. 26, 2004.
Decided Dec. 30, 2004.

Background: Proceeding was brought for appointment of limited guardian to make medical decisions for infant, including withdrawal of life support. The Court of Common Pleas, Summit County, Probate Division, No. 2004 GA 0086, appointed a limited guardian. Parents appealed. The Court of Appeals, 157 Ohio App.3d 417, 2004-Ohio-2948, 811 N.E.2d 594, affirmed. Discretionary appeal was accepted.

Holding: The Supreme Court, Lundberg Stratton, J., held that the probate court's statutory authority to appoint a limited guardian for an infant did not give the probate court authority to vest the limited guardian with power to withdraw all life-sustaining support, in absence of termination of parental rights.

Reversed and remanded.

O'Donnell, J., filed a concurring opinion.
Moyer, C.J., filed an opinion concurring in part and dissenting in part.
Pfeifer, J., filed an opinion concurring in part and dissenting in part.
O'Connor, J., filed a dissenting opinion.

EXHIBIT #1

West Headnotes
[1] KeyCite this headnote
198H Health
198HVI Consent of Patient and Substituted Judgment
198Hk913 Terminal Illness; Removal of Life Support
198Hk915 k. Substituted Judgment; Role of Courts, Physicians, Guardians, Family or Others.
Probate court's statutory authority to appoint a limited guardian for an infant did not give the probate court authority to vest the limited guardian with power to withdraw all life-sustaining support, in absence of termination of parental rights. (Per Lundberg Stratton, J., with two Justices concurring and two Justices concurring separately.) R.C. §§ 2111.06, 2111.50(F), 2133.08.

[2] KeyCite this headnote
196 Guardian and Ward
196II Appointment, Qualification, and Tenure of Guardian
196k8 k. Jurisdiction of Courts.
Infant hospitalized within county on 24-hour, seven-day-per-week basis, while in persistent vegetative state, was a resident of that county, for purposes of statute giving probate court jurisdiction to appoint a guardian who resides in the county in which the infant resides. (Per Lundberg Stratton, J., with two Justices concurring and two Justices concurring separately.) R.C. § 2111.02(A).

[3] KeyCite this headnote
198H Health
198HVI Consent of Patient and Substituted Judgment
198Hk913 Terminal Illness; Removal of Life Support
198Hk915 k. Substituted Judgment; Role of Courts, Physicians, Guardians, Family or Others.
The Uniform Rights of the Terminally Ill Act, which explicitly authorizes the removal of life-sustaining treatment from adults, does not authorize the removal of life-sustaining treatment from infants. (Per Lundberg Stratton, J., with two Justices concurring and three Justices concurring separately.) R.C. § 2133.08.
**1009 E.P. Markovich Co., L.P.A., and Edward P. Markovich, Akron, for appellants.
Brouse McDowell, Linda B. Kersker, Jay E. Krasovec, and Clair E. Dickinson, Akron, for appellee Ellen Kaforey, guardian.
David Kitzler, Mansfield, for appellee Richland County Children Services Board.

LUNDBERG STRATTON, J.
[1] {¶ 1}*30 Today this court must consider the narrow legal issue of whether the Summit County Probate Court exceeded its statutory authority when it appointed a guardian with the power to authorize the withdrawal of all life-sustaining support and treatment for Aiden Stein, an infant. Although the unique facts of this case are tragic and raise many issues, this case does not require us to decide whether either of Aiden Stein's parents abused him or whether Aiden's father, appellant Matthew Stein, is guilty of any criminal charges. It does not require us to decide whether it would be in Aiden's best interest to have life-supporting *31 treatments

withdrawn and comfort care administered or whether the constitutional rights of his parents were violated. Rather, this case involves a narrow legal issue of statutory authority.

{¶ 2} For the reasons that follow, we conclude that the probate court exceeded its statutory authority, and we, therefore, remand the cause to the Summit County Probate Court to amend the guardianship order to remove the portion of the order authorizing the guardian to withdraw life-supporting treatment for Aiden.

History

{¶ 3} On March 15, 2004, five-month-old Aiden Stein was taken from his home to MedCentral Hospital, Mansfield, in Richland County by emergency transport. When Aiden arrived at MedCentral, he was in critical condition, not moving, and unable to breathe on his own. He was placed on a mechanical ventilator, resuscitated, and transferred to Akron Children's Hospital Medical Center of Akron in Summit County.

{¶ 4} Upon arrival at Children's Hospital, Aiden was found to have excessive amounts of blood on his brain. He was moved to the critical care unit, where doctors attempted to drain some of the excess blood from his head. In the emergency department, Aiden was diagnosed as having suffered a traumatic brain injury.

{¶ 5} Dr. Richard D. Steiner, D.O., an attending physician in the emergency department at Children's Hospital, was called to evaluate Aiden soon after his arrival. Dr. Steiner testified that because of the child's age, there was a suspicion by the emergency room physicians that Aiden may have suffered the injury as a result of abuse.

{¶ 6} Aiden's sole caretaker on the day he sustained these injuries was his father, Matthew Stein ("Stein"). In addition, there was evidence of a possible prior incident of abuse, regarding which neither parent could be ruled out as a suspect. On March 16, 2004, appellee Richland County Children Services Board ("RCCSB") was **1010 granted emergency temporary custody of Aiden based upon the above diagnosis and allegations that the injuries were inflicted by Stein, with whom Aiden's mother, appellant Arica Heimlich, was residing.

{¶ 7} Aiden's prognosis, based on a reasonable degree of medical certainty, is that he will have no awareness of or ability to interact with his environment other than reflexive actions. Three of four doctors who testified at the hearing opined that, at best, Aiden's outcome would be a permanent unconscious state, also described as a persistent vegetative state.

{¶ 8} Due to Aiden's diagnosis and prognosis, the Children's Hospital Ethics Committee was consulted regarding ethical issues involved in continuing, limiting, *32 or withdrawing life-supporting treatment for Aiden. The ethics committee is a multidisciplinary group of people, including physicians, nurses, therapists, community members, clergy, and legal counsel, and is not associated with the hospital. Because Stein was under suspicion of causing Aiden's injuries, and because Heimlich remained allied with Stein after the alleged abuse, the committee recommended that due to the significant potential for a conflict of interest, a guardian should be appointed to help make medical decisions for Aiden. In addition, the ethics committee recommended that life-supporting treatment be withdrawn and comfort care be administered to Aiden.

{¶ 9} On April 6, 2004, at the request of Children's Hospital, appellee Ellen Kaforey applied to the Summit County Probate Court for appointment as Aiden's guardian "to evaluate and determine the withdrawal of life-sustaining medical treatment currently being administered" to Aiden. Kaforey is an attorney and a registered nurse who is often called upon by the probate court to assist families in cases where medical decisions need to be made for a family member.

{¶ 10} The Summit County Probate Court held an evidentiary hearing on Kaforey's application on April 14, 16, 21, and 22, 2004. At the hearing, testimony was taken from Aiden's parents, Stein and Heimlich, Dr. John Pope, Ellen Kaforey, Michelle Renee Flaherty (an investigator for RCCSB), Dr. Richard Steiner, Janet Roberts (a licensed practical nurse), Leanne Sessler (sister of Arica Heimlich), Dr. Max Wiznitzer, and Dr. Paul A. Byrne.

{¶ 11} Dr. John Pope, a pediatrician and critical care pediatric specialist at Children's Hospital, testified that Aiden's condition was consistent with shaken baby syndrome. He testified that Aiden had "tremendous intracranial injuries inside of his skull, blood around his brain, as well as significant evidence on [the] CT of injury to the brain itself, and also had a significant amount of bleeding in the back of his eyes or retinal hemorrhages. These injuries without a history of an immediately preceding significant traumatic event are only consistent with shaken baby syndrome."

{¶ 12} Dr. Pope testified that Aiden "not only suffered from the bleeding and the direct traumatic injury, but the brain, his upper brain, the cortex, the parts of the brain that makes us who we are, suffered for some period of time [from] inadequate oxygen and inadequate blood flow."

{¶ 13} Further, Dr. Pope testified that Aiden's most recent CAT scan at that time, which was March 22, "showed that part of the brain to be essentially completely black which is an indication that that part of the brain is dead." A subsequent x-ray showed that Aiden also had a fractured skull, which Dr. Pope testified was consistent with a "discard injury," occurring when a victim of shaken baby syndrome is tossed aside after having been **1011 shaken. Dr. Pope testified that *33 Aiden was the victim of shaken infant syndrome and that he will remain in a persistent vegetative state until he dies.

{¶ 14} Dr. Steiner, attending physician at Children's Hospital Department of Emergency Medicine, testified that Aiden was the victim of shaken infant syndrome, and he concurred with Dr. Pope's prognosis that Aiden will remain in a persistent vegetative state until he dies.

{¶ 15} Dr. Max Wiznitzer, appointed by the court as an independent medical reviewer, is on staff at Rainbow Babies and Children's Hospital, Department of Pediatrics, and at University Hospitals of Cleveland, Department of Neurology. Dr. Wiznitzer testified that Aiden was the victim of shaken infant syndrome and that he will remain in a persistent vegetative state until he dies.

{¶ 16} Dr. Paul Byrne testified on behalf of Aiden's parents. Dr. Byrne testified that he had examined Aiden and reviewed the file and concluded that Aiden's injuries were not caused by shaken infant syndrome. Rather, Dr. Byrne testified that Aiden had a preexisting condition and that an unspecified acute event sent him into respiratory arrest. He testified that the withdrawal of life-sustaining medical treatment was not appropriate. When asked whether there are any circumstances where the withdrawal of life-sustaining

medical treatment is ethically appropriate, Dr. Byrne responded, "Let's put it this way, I haven't seen that."

{¶ 17} On the second day of the hearing, the parties reached an agreement that the court could move forward to appoint Ellen Kaforey as the guardian of Aiden Stein for limited purposes, defined to include making all medical decisions with the exception of the withdrawal of life-sustaining treatments, for Aiden Stein from that point forward until further order of the court.

{¶ 18} Following the hearing, on April 29, 2004, the probate court appointed Ellen Kaforey as "limited guardian" of Aiden Stein, but, despite the agreement, ordered that her powers include (1) giving consent to all medical treatment, (2) withdrawing all life-sustaining support and treatment, (3) requesting a do- not-resuscitate order, (4) directing the infant's medical care providers to cease all medical treatment that would prolong the life of the infant, and (5) making recommendations regarding Aiden's eventual disposition if he requires posthospital care elsewhere.

{¶ 19} R.C. 2133.08 authorizes the removal of life-sustaining treatment for terminally ill adults. However, the probate court concluded that R.C. 2133.08 "arguably" does not apply to minors, and, therefore, the court instead derived its authority from R.C. 2111.06, a general statute that authorizes the probate court to appoint a guardian to make medical and other decisions for a minor if the parents are unsuitable.

{*34 ¶ 20} The Summit County Court of Appeals affirmed the judgment of the probate court on June 9, 2004. In re Guardianship of Stein, 157 Ohio App.3d 417, 2004-Ohio-2948, 811 N.E.2d 594. This court granted the appellant parents' motion to stay execution of the court of appeals' judgment on June 11, 2004. In re Guardianship of Stein, 102 Ohio St.3d 1475, 2004-Ohio-2995, 810 N.E.2d 441.

{¶ 21} This cause is now before us upon our acceptance of a discretionary appeal.

Jurisdiction

[2] {¶ 22} R.C. 2101.24(A)(1) defines the jurisdiction of the probate court:

{¶ 23} "Except as otherwise provided by law, the probate court has exclusive jurisdiction:

{¶ 24} "* * *

**1012 {¶ 25} "(e) To appoint and remove guardians * * *."

{¶ 26} The probate court concluded that Aiden is a resident of Summit County as required by R.C. 2111.02(A), a conclusion with which we agree. A minor's resident status is to be construed consistently with the best interest of the minor. See In re Fore (1958), 168 Ohio St. 363, 369, 7 O.O.2d 127, 155 N.E.2d 194. Further, "residence" refers to a place of dwelling within the state. Id. at 371, 7 O.O.2d 127, 155 N.E.2d 194. Since being admitted to Akron Children's Hospital on March 15, 2004, Aiden has been residing in Summit County on a 24-hour, seven-day-per-week basis. Moreover, the parties do not appear to contest the probate court's finding of residency or of jurisdiction. We, therefore, hold that Aiden is a resident of Summit County for purposes of this case under R.C. 2111.02(A), and the probate court had jurisdiction to consider these questions.

Guardianship

{¶ 27} "[A] parent's desire for and right to 'the companionship, care, custody and management of his or her children' is an important interest that 'undeniably warrants deference and, absent a powerful countervailing interest, protection.' " Lassiter v. Dept. of Social Serv. (1981), 452 U.S. 18, 27, 101 S.Ct. 2153, 68 L.Ed.2d 640, quoting Stanley v. Illinois (1971), 405 U.S. 645, 651, 92 S.Ct. 1208, 31 L.Ed.2d 551.

{¶ 28} Ellen Kaforey filed for guardianship of Aiden Stein after the Ethics Committee at Akron Children's Hospital concluded that Aiden's parents have a conflict of interest regarding Aiden's care due to the potential for enhanced criminal charges if Aiden dies. R.C. 2111.06 provides that "[a] guardian of the person of a minor shall be appointed as to a minor * * * whose parents are unsuitable persons to have the custody and tuition of such minor."

{*35 ¶ 29} The probate court granted that application and granted to Kaforey the authority to withdraw life-supporting treatments for Aiden. Stein and Heimlich contend that any decision to remove life-supporting treatment from Aiden would have the effect of terminating their parental rights without due process. The RCCSB and Guardian Kaforey argue that if life-supporting treatments are withdrawn and Aiden dies, it would be the neurological injuries Aiden sustained that would be the cause of death, not the act of withdrawing the life-supporting treatments.

[3] {¶ 30} R.C. 2133.08, part of Ohio's version of the Uniform Rights of the Terminally Ill Act, is the only Ohio statute that explicitly authorizes the removal of life-sustaining treatment. The statute, by its very terms, however, applies only to adults. R.C. 2133.08(A)(1). If a statute is unambiguous, we must apply it as written. State v. Hairston, 101 Ohio St.3d 308, 2004-Ohio-969, 804 N.E.2d 471, ¶ 13. See, also, State v. Hughes (1999), 86 Ohio St.3d 424, 427, 715 N.E.2d 540 ("In construing a statute, we may not add or delete words"). If the General Assembly wanted to apply R.C. 2133.08 to minors, it could have expressly done so. Because it has not, we will not extend the statute's application by judicial decree. Thus, the probate court correctly concluded that R.C. 2133.08 does not permit the withdrawal of life-sustaining treatment for a minor.

{¶ 31} The probate court then turned to R.C. Chapter 2111, concerning guardianships and conservatorships. Specifically, R.C. 2111.50(F) provides that "[w]hen considering any question related to, and issuing orders for, medical or surgical care or treatment of incompetents or minors subject to guardianship, the probate court has full parens patria powers unless otherwise **1013 provided by a section of the Revised Code." Moreover, R.C. 2111.06 provides that "[a] guardian of the person of a minor shall be appointed as to a minor * * * whose parents are unsuitable persons to have the custody and tuition of such minor."

{¶ 32} Aiden's parents have been considered unsuitable due to the conflict of interest that exists in this case, namely, if life-supporting treatments are withdrawn, Aiden will die, and if Aiden dies, his father, who was the sole caretaker on the day Aiden sustained his injuries, could be charged with murder, as he is suspected of injuring the baby. Further, Aiden's mother, Heimlich, who resides with and has since become engaged to Stein, does not believe that Stein caused Aiden's injuries, and neither can be ruled out as having caused a possible prior incident of abuse.

{¶ 33} In accordance with R.C. 2111.06, the probate court in this instance concluded that it had the jurisdiction to appoint a guardian for the purpose of making or recommending medical decisions for Aiden, including life-and-death issues of removing life-sustaining

treatments. We find, however, that the decision *36 to withdraw life-supporting treatments goes beyond the scope of making medical decisions.

{¶ 34} The Richland County Juvenile Court placed Aiden in the emergency temporary protective custody of the RCCSB on March 16, 2004. On October 26, 2004, at the time this court heard this case on the merits, permanent custody of Aiden had not been determined, and he remained in the temporary custody of the RCCSB.

{¶ 35} In this case, the parents' rights have been merely suspended, not terminated. We acknowledge the argument that the abuse would be the true proximate cause of Aiden's death should life-supporting treatments be withdrawn. However, many scenarios are possible in this unique case, such as the possibility that Heimlich could choose to leave Stein and seek sole custody of Aiden. If it cannot be established that she participated in any of the possible instances of abuse, there may not be grounds to deny her reunification with her son. The fact that a child is in a permanent vegetative state is not a sufficient reason to deny parental rights, absent evidence of abuse or neglect. The right to withdraw life-supporting treatment for a child remains with the child's parents until the parents' rights are permanently terminated.

{¶ 36} "The fundamental liberty interest of natural parents in the care, custody, and management of their child does not evaporate simply because they have not been model parents or have lost temporary custody of their child to the State. Even when blood relationships are strained, parents retain a vital interest in preventing the irretrievable destruction of their family life. If anything, persons faced with forced dissolution of their parental rights have a more critical need for procedural protections than do those resisting state intervention into ongoing family affairs. When the State moves to destroy weakened familial bonds, it must provide the parents with fundamentally fair procedures." Santosky v. Kramer (1982), 455 U.S. 745, 753-754, 102 S.Ct. 1388, 71 L.Ed.2d 599.

{¶ 37} We conclude that the probate court's order authorizing the guardian to withdraw life-supporting treatments has the effect of terminating parental rights. We, therefore, hold that the probate court exceeded its statutory authority in granting the guardian the power to withdraw life-supporting treatments before the parents' rights were permanently terminated. If the Richland County Juvenile Court permanently terminates the parental **1014 rights of Stein and Heimlich, the guardian will then fully stand in the shoes of the parents. Until then, the granting of authority to withdraw life-supporting treatment for Aiden is premature.

{¶ 38} The heartbreak and tragedy in this case cannot be overstated. However, we believe that without a full and proper adjudication of parental rights concluding in a termination of those rights, a probate court has no authority to *37 allow a guardian to make a decision that will terminate the life of a child, when parental rights have not been permanently terminated, thereby terminating the parent-child relationship. Accordingly, because the parties have otherwise stipulated to the order of the Summit County Probate Court, we remand the cause to the Summit County Probate Court to amend the guardianship order to remove the portion of the order authorizing the guardian to withdraw life-supporting treatments for Aiden.

Judgment reversed and cause remanded.

RESNICK and FRANCIS E. SWEENEY, SR., JJ., concur.

O'DONNELL, J., concurs separately.

MOYER, C.J., concurs in part and dissents in part.

PFEIFER, J., concurs in part and dissents in part.

O'CONNOR, J., dissents.

O'DONNELL, J., concurring.

{¶ 39} The majority has correctly concluded that the judgment of the court of appeals should be reversed; I write separately to emphasize the fact that the Richland County Juvenile Court had exercised jurisdiction over Aiden Stein, had not terminated parental rights, and in my view, never relinquished its jurisdiction over the custody of the infant.

{¶ 40} Against that factual background, after the infant was transported to Akron Children's Hospital in Summit County and at the request of the hospital, Ellen Kaforey, an attorney and a nurse, applied to the probate court to serve as guardian for the infant.

{¶ 41} The parties consented to her appointment, but not to her authority to withdraw life support; despite the agreement, the Summit County Probate Court granted her that authority.

{¶ 42} Two questions arise: one, which court should be acting on the infant's behalf, and two, does the statute authorize a probate court to terminate life support of a minor? The answer to the first question is that the Richland County Juvenile Court has jurisdiction over this child and the answer to the second is that the legislature has not provided authority to a probate court to exercise this jurisdiction. Decisions of this kind involving minors are properly left to parents. Unless or until their rights as to their child are terminated, they are the proper parties to make the decision with respect to their own child.

{*38 ¶ 43} I do not agree that a guardian is in a position to make decisions regarding the termination of life support for Aiden if the Richland County Juvenile Court does terminate parental rights. Juvenile courts of our state must consider the best interest of the child in making custody decisions and must place custody of the child with the party best suited to provide care. See, generally, R.C. 2151.353 and 2151.414.

{¶ 44} The General Assembly recognized the role of parents and the duty of courts to defer to the decisions of parents or those who exercise parental rights and, in enacting R.C. 2133.08 regarding the **1015 rights of the terminally ill, specifically chose to extend application only to adults, and not to minors.

{¶ 45} Therefore, in my view, the Summit County Probate Court abused its discretion in authorizing the guardian to terminate life support for Aiden Stein. Accordingly, I concur with the majority in its decision to order the Summit County Probate Court to amend its judgment deleting the authority to withdraw life support, because that is not authorized by R.C. 2133.08, but I would also remand the matter to the Richland County Juvenile Court for further proceedings regarding the adjudication of parental rights.

MOYER, C.J., concurring in part and dissenting in part.

{¶ 46} We live in a technological age in which the dividing line between life and death is sometimes a fine one. Aiden Stein "lives" because his heart is beating and his body is capable of sustaining itself when provided nutrition, water, and technological assistance. We are told that every area of his brain, however, has been significantly damaged except for the "very deep center of the brain stem which is the very primitive area of the brain." The clear consensus of medical opinion is that Aiden's ability to relate to people and events around him no longer exists--and will never return. He is described as being in a persistent vegetative state with no chance for recovery. The trial court described Aiden's existence as "not life but a cruel shadow of life."

{¶ 47} Ethical people of good will disagree as to what is in the best interest of a person under such circumstances. I agree with the majority that the ultimate inquiry before us is not whether life-supporting treatment should be continued. Rather, the ultimate question we must resolve is whether Aiden's parents retain the legal right to make that decision, even though one parent is suspected of (but not charged with) causing Aiden's injuries and the other believes in the father's innocence. Or did the state, acting through the probate court and in light of the accusations against one or both of Aiden's parents, validly vest a guardian with *39 the limited authority to make the decision whether life-supporting treatment should be continued? The issue is Solomonic.

{¶ 48} As does the majority, I acknowledge that the right of natural parents to direct the care and upbringing of a child is a fundamental liberty interest of constitutional dimension. Troxel v. Granville (2000), 530 U.S. 57, 65, 120 S.Ct. 2054, 147 L.Ed.2d 49. However, that authority is not unlimited. The state clearly has parens patriae power over minors in certain circumstances.

{¶ 49} Ohio courts do not, however, have inherent jurisdiction to determine a child's best interests, as they possess only the jurisdiction that the General Assembly has expressly conferred upon them. See Section 4(B), Article IV of the Ohio Constitution; Seventh Urban, Inc. v. Univ. Circle Property Dev., Inc. (1981), 67 Ohio St.2d 19, 22, 21 O.O.3d 12, 423 N.E.2d 1070. Thus the question remains whether Ohio's statutory scheme grants the trial court the authority to terminate Aiden's life support contrary to the will of his parents.

{¶ 50} The trial court proceeded under the authority of R.C. 2111.02 and 2111.06. R.C. 2111.02 states:

{¶ 51} "(A) When found necessary, the probate court * * * shall appoint * * * a guardian of the person, the estate, or both, of a minor * * *.

{¶ 52} "* * *

{¶ 53} "(B)(1) If the probate court finds it to be in the best interest of [a] * * * **1016 minor, it may appoint * * * on its own motion or on application by an interested party, a limited guardian with specific limited powers. * * * [T]he order of appointment and letters of authority of a limited guardian shall state the reasons for, and specify the limited powers of, the guardian. The court may appoint a limited guardian for a definite or indefinite period. * * *

{¶ 54} "(C) Prior to the appointment of a * * * limited guardian under division (A) or (B)(1) of this section, the court shall conduct a hearing on the matter of the appointment." (Emphasis added.)

{¶ 55} R.C. 2111.06 provides:

{¶ 56} "A guardian of the person of a minor shall be appointed as to a minor having neither father nor mother, or whose parents are unsuitable persons to have the custody and tuition of such minor, or whose interests, in the opinion of the court, will be promoted thereby. A guardian of the person shall have the custody and provide for the maintenance of the ward, and if the ward is a minor such guardian shall also provide for the education of such ward." (Emphasis added.)

{¶ 57} R.C. 2111.02 and 2111.06 vest the probate courts of Ohio with broad power. Upon a mere finding that it is in the "best interest of a * * * minor," R.C. 2111.02(B)(1) authorizes a probate court to supplant a parent's rights and *40 responsibilities through appointment of a limited guardian. Similarly, R.C. 2111.06 authorizes a probate court to appoint a guardian of a minor not only where the court finds the child's natural parents to be "unsuitable persons" but also upon the mere finding that the child's "interests * * * will be promoted thereby."

{¶ 58} These conclusory statutory criteria stand in stark contrast to the comprehensive statutory scheme set forth in R.C. Chapter 2151 governing the adjudication of children as dependent, neglected, or abused, and ultimately, the permanent termination of a natural parent's legal rights. Indeed, where parents are believed to be unfit, R.C. Chapter 2151 is more commonly invoked to accomplish transfer of responsibility for children from natural parents to the state than is the probate code.

{¶ 59} Nevertheless, R.C. 2111.02 clearly authorizes a probate court to appoint a limited guardian where the court finds it to be in the child's best interests to do so. Nothing in the text of the statute precludes the court from authorizing a limited guardian to direct a child's medical provider to terminate life support.

{¶ 60} I do not accept the majority's premise that a decision to withdraw life-supporting treatments is something other than a medical decision. Nor do I believe that a decision to withdraw life-supporting treatments is equivalent to the termination of the parent-child relationship. That relationship is legal in nature, and while the death of either clearly changes it, the relationship survives death. See, for example, the statute of descent and distribution, R.C. 2105.06(F), providing that a surviving parent is entitled to inherit from the estate of a deceased child not survived by a spouse or his or her own children.

{¶ 61} In short, I believe that the General Assembly has authorized probate courts to enter orders like that made by the Probate Court of Summit County.

{¶ 62} I believe that the question whether R.C. 2111.02 and 2111.06 were constitutionally applied to Aiden's parents is a separate, serious, and legitimate one. The court of appeals refused to address it, observing that the parents first raised constitutional objections "during their closing argument at the conclusion of a four-day hearing, when it was clearly too late for **1017 the trial court to correct the alleged error."

{¶ 63} I disagree. It is true that counsel's advocacy was less than artful and that he did not specifically argue that application of the guardianship statutes to Aiden's parents would be unconstitutional. I cannot subscribe to the premise, however, that constitutional issues were waived because not raised "at a time when such error could have been avoided or corrected by the trial court." State v.

Childs (1968), 14 Ohio St.2d 56, 43 O.O.2d 119, 236 N.E.2d 545, paragraph three of the syllabus.
{*41 ¶ 64} Counsel for Aiden's parents stated at closing argument:
{¶ 65} "The issue in this case is not merely jurisdiction * * *. This court's primary jurisdiction over guardianship, your Honor, is a mere footnote to the fundamental interest in life, liberty and property which is the core constitutional issue in this case.
{¶ 66} "* * *
{¶ 67} "This constitutional issue is--partakes of the First Amendment, your Honor, the associative right of the parent, the Fifth Amendment in the depravation [sic] of a human life, and most particularly the Fourteenth Amendment through the state's participation through the person of this honorable court in making this decision. And, your Honor, I do not question the jurisdiction of the Court, I simply request that the fundamental due process to be accorded my clients be permitted to proceed just as this application for a best interest substitute of judgment has been permitted to proceed.
{¶ 68} "* * *
{¶ 69} "And respectfully, your Honor, * * * I'm asking this Court to reconsider its own opinion in [a prior analogous case] and that's because of the constitutional issues presented * * *.
{¶ 70} "* * *
{¶ 71} "My clients have * * * not been permitted their procedural due process and substantive due process rights before the state of Ohio."
{¶ 72} In my view, these comments adequately preserved constitutional issues for appellate review. The trial court clearly was put on notice that Aiden's parents believed that their constitutional rights were in jeopardy before the trial court granted the guardianship application. The fact that the written trial court decision granting the guardianship did not address these issues does not mean that they were not raised. Nor did they waive their constitutional rights by stipulating that a guardian would be appointed to make medical decisions not involving the termination of life support. I note, moreover, that "[e]ven where waiver is clear, this court reserves the right to consider constitutional challenges to the application of statutes in specific cases of plain error or where the rights and interests involved may warrant it." (Emphasis added.) In re M.D. (1988), 38 Ohio St.3d 149, 527 N.E.2d 286, at syllabus (reviewing the constitutionality of a statute as applied even though the constitutional challenge was presented at the trial court "in general terms"). Id. at 151, 527 N.E.2d 286.
{¶ 73} In Troxel, the Supreme Court of the United States reviewed a Washington visitation statute invoked by grandparents Jenifer and Gary Troxel. The statute permitted " '[a]ny person' to petition a superior court for visitation rights 'at any time,' and authorize[d] that court to grant such visitation rights whenever*42 'visitation may serve the best interest of the child.' " Id., 530 U.S. at 60, 120 S.Ct. 2054, 147 L.Ed.2d 49. The children's mother did not object to a grant of some visitation, but asked the **1018 court to order only one day of visitation per month, with no overnight stay. The superior court, however, entered a visitation order allowing the grandparents more extensive visitation based on its conclusion that more extensive visitation was in the children's best interests.
{¶ 74} Justice O'Connor of the Supreme Court of the United States concluded, in a plurality opinion, that, as applied, the "breathtakingly broad" Washington statute exceeded the bounds of the Due Process Clause. Id. at 67, 120 S.Ct. 2054, 147 L.Ed.2d 49. She concluded that the Washington trial court had "directly contravened the traditional presumption that a fit parent will act in the best interest of his or her child," and specifically noted that the grandparents "did not allege, and no court has found, that [the mother] was an unfit parent." Id. at 69 and 68, 120 S.Ct. 2054, 147 L.Ed.2d 49. The latter aspect of the case was characterized as "important." Id. at 68, 120 S.Ct. 2054, 147 L.Ed.2d 49.
{¶ 75} Notably, in the case at bar, allegations of unfitness have been made against one, if not both, of Aiden's parents. The trial court did not, however, find that either parent was responsible for Aiden's injuries, only that they may have been responsible. [FN1]

FN1. {¶ a} The trial court appointed a limited guardian based on the following reasoning:

{¶ b} "Matthew Stein has allegedly abused Aiden Stein * * *. Matthew Stein is the subject of a criminal investigation related to the infliction of Aiden's current injuries and will undoubtedly be charged with homicide or negligent homicide if Aiden is allowed to die from the underlying cause of his condition. Further, the mother, Arica, supports the father's assertion that he is not to blame for the current injuries. Additionally, there is
evidence that Aiden Stein has suffered prior brain bleeds consistent with nonaccidental trauma. Neither Arica Heimlich or Matthew Stein can be ruled out as suspects in the prior injury or injuries that Aiden has suffered. Therefore, Arica Heimlich and Matthew Stein are in a position of a conflict of interest and are unsuitable such that this Court in its role as parens patriae has a duty to act in the best interest of Aiden Stein and appoint a neutral third party as limited guardian to make medical decisions on his behalf." (Emphasis added.)

{¶ 76} After Troxel it is unclear whether, and under what circumstances, a state may constitutionally override a fit parent's decision as to the care or upbringing of a child based on the state's disagreement with the parent's conclusion as to a child's best interests. ("Our cases, it is true, have not set out exact metes and bounds to the protected interest of a parent in the relationship with his child." Id., 530 U.S. at 78, 120 S.Ct. 2054, 147 L.Ed.2d 49 [Souter, J., concurring in judgment].) It seems clear, however, that "the Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a 'better' decision could be made," id. at 72-73, 120 S.Ct. 2054, 147 L.Ed.2d 49, and that a court *43 must accord "special weight" to a fit parent's determination of the child's best interests, id. at 70, 120 S.Ct. 2054, 147 L.Ed.2d 49.
{¶ 77} It is not overly dramatic to observe that this case presents a life-and-death issue and implicates one of our society's most precious and fundamental interests--the rights of parents in their relationship with their children. For this reason I believe that this cause should be reversed and remanded to the court of appeals with instructions that it consider the constitutional implications of the

• 2004 WL 2542417 (Appellate Brief) Brief of Richland County Children Services Board (Oct. 15, 2004)
• 2004 WL 2475709 (Appellate Brief) Brief of Appellants Matthew Stein and Arica Heimlich (Oct. 01, 2004)
• 2004 WL 5305718 (Appellate Petition, Motion and Filing) Memorandum in Support of Jurisdiction of Appellants Matthew Stein and Arica Heimlich (Jul. 26, 2004)
END OF DOCUMENT

COURT OF APPEALS
RICHLAND COUNTY, OHIO
FIFTH APPELLATE DISTRICT

STATE OF OHIO

Plaintiff-Appellee

-vs-

MATTHEW STEIN

Defendant-Appellant

JUDGES:
Hon. W. Scott Gwin, P. J.
Hon. Sheila G. Farmer, J.
Hon. John W. Wise, J.

Case No. 05 CA 103

OPINION

CHARACTER OF PROCEEDING: Criminal Appeal from the Court of Common Pleas, Case No. 05 CR 224D

JUDGMENT: Affirmed

DATE OF JUDGMENT ENTRY:

APPEARANCES:

For Plaintiff-Appellee

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ASSISTANT PROSECUTOR
38 South Park Street
Mansfield, Ohio 44902

For Defendant-Appellant

EDWARD P. MARKOVICH
209 South Main Street
Suite 201
Akron, Ohio 44308

EXHIBIT
Appx #2

Wise, J.

{¶1} Appellant Matthew Stein appeals from his conviction for felonious assault in the Court of Common Pleas, Richland County. The relevant facts leading to this appeal are as follows.

{¶2} On October 27, 2003, Aiden Stein was born to Arica Heimlich and Appellant Matthew Stein. Aiden was born with his umbilical cord around his neck, but he suffered no trauma as a result. For the first four and one-half months of his life, Aiden was generally a normally developing baby boy. On March 14, 2004, Arica, his mother, woke Aiden up and fed him at approximately 6:30 AM. When she left for work at 7:43 AM, leaving Aiden in appellant's care, the baby appeared fine. However, at about 10:30 AM that day, appellant banged on the door of his neighbor, Gerald Holland, stating that Aiden had stopped breathing.

{¶3} Holland immediately took the baby from appellant's arms and checked him for signs of choking. Finding nothing, Holland began performing CPR and directed his girlfriend to call 911. Paramedics arrived about five minutes later and transported Aiden to Med Central Hospital. The emergency room physician, Dr. Anthony Midkiff, was told by the paramedics and appellant that the baby had gagged while nursing from a bottle. Dr. Midkiff later testified that he did not see the usual symptoms of choking in Aiden during the examination.

{¶4} Aiden was intubated and transported by helicopter to Akron Children's Hospital. Dr. Daryl Steiner thereupon took over treatment of Aiden. A CT scan revealed evidence of extensive bleeding around Aiden's brain, as well as indications of "older" blood in the baby's subdural region. Dr. Steiner further observed indication of

brain swelling and discovered a skull fracture on the left side of Aiden's skull. Dr. Steiner also observed Aiden had severe retinal hemorrhages, not in the nature of hemorrhages caused by birth. His eventual diagnostic conclusion was that Aiden had suffered brain damage caused by physical abuse. Two other examining physicians at Akron Children's, Dr. Vivek Malhotra and Dr. John Pope, concurred in the diagnosis.

{¶5} In the meantime, the Mansfield Police Department and Richland County Children's Services began an investigation concerning Aiden's injuries, which had left him in a permanent vegetative state. On April 7, 2005, the Richland County Grand Jury indicted appellant on one count of felonious assault and one count of child endangering, both felonies of the second degree. The matter proceeded to a jury trial which commenced on August 25, 2005, and lasted until September 7, 2005. The State's theory of the case was premised on Shaken Baby Syndrome. At the conclusion of the trial, the jury found appellant guilty on both counts of the indictment.

{¶6} A sentencing hearing was conducted on September 12, 2005. The trial court thereupon imposed the statutory maximum sentence of eight years in prison for the offense of felonious assault. The court further found the child endangering charge to be an allied offense of similar import; hence, appellant was not sentenced for said offense.

{¶7} On October 13, 2005, appellant filed a notice of appeal. He herein raises the following sole Assignment of Error:

{¶8} "I. THE INEFFECTIVENESS OF DEFENSE COUNSEL VIOLATED APPELANT'S (SIC) RIGHT TO COUNSEL UNDER THE SIXTH AMENDMENT TO THE

UNITED STATES CONSTITUTION AND ARTICLE I, S. 16 OF THE OHIO CONSTITUTION."

I.

{¶9} In his sole Assignment of Error, appellant contends he was deprived of his right to the effective assistance of counsel at trial. We disagree.

{¶10} Our standard of review is set forth in *Strickland v. Washington* (1984), 466 U.S. 668, 104 S.Ct. 2052, 80 L.Ed.2d 674. Ohio adopted this standard in the case of *State v. Bradley* (1989), 42 Ohio St.3d 136, 538 N.E.2d 373. These cases require a two-pronged analysis in reviewing a claim for ineffective assistance of counsel. First, we must determine whether counsel's assistance was ineffective; i.e., whether counsel's performance fell below an objective standard of reasonable representation and was violative of any of his or her essential duties to the client. If we find ineffective assistance of counsel, we must then determine whether or not the defense was actually prejudiced by counsel's ineffectiveness such that the reliability of the outcome of the trial is suspect. This requires a showing that there is a reasonable probability that but for counsel's unprofessional error, the outcome of the trial would have been different. Id. Trial counsel is entitled to a strong presumption that all decisions fall within the wide range of reasonable professional assistance. *State v. Sallie* (1998), 81 Ohio St.3d 673, 675, 693 N.E.2d 267.

Seating of Jurors Schwartz and Smith

{¶11} Appellant first argues that his trial counsel was ineffective for failing to object to the seating of two jurors, Allen Schwartz and Lindsey Smith, who he alleges had "direct connections" to certain witnesses in the case.[1] Appellant's Brief at 5.

{¶12} "[T]he selection and qualification of jurors are largely under the control of the trial court and, unless an abuse of discretion is clearly shown with respect to rulings thereon, they will not constitute ground for reversal:" *State v. Trummer* (1996), 114 Ohio App.3d 456, 461, 683 N.E.2d 392, citing *Berk v. Matthews* (1990), 53 Ohio St.3d 161, 559 N.E.2d 1301.

{¶13} Appellant herein chiefly raises the issue of "implied bias," a principle we have previously addressed only in limited fashion. See *State v. Winegardner* (Feb. 1, 1984), Licking App.No. CA-2958. In *State v. Vasquez*, Franklin App.No. 03AP-460, 2004-Ohio-3880, the court recognized: "Because the bias of a juror will rarely be admitted by the juror himself, partly because the juror may have an interest in concealing his own bias and partly because the juror may be unaware of it, it necessarily must be inferred from surrounding facts and circumstances." Id. at ¶ 14, quoting *McDonough Power Equipment, Inc. v. Greenwood* (1984), 464 U.S. 548, 558, 104 S.Ct. 845, 849, 78 L.Ed.2d 663, Brennan, J., concurring (internal quotations and additional citations omitted).

{¶14} "[C]ourts have been inclined to presume bias in 'extreme' situations where the prospective juror is connected to the litigation at issue in such a way that is highly unlikely that he or she could act impartially during deliberations." *Vasquez*, supra, at ¶

[1] Appellant also briefly mentions Juror Birmelin in his brief, but does not develop the argument. See App.R. 16(A)(7).

14. Nonetheless, a juror " * * * ought not to suffer a challenge for cause when the court is satisfied from an examination of the prospective juror or from other evidence that the prospective juror will render an impartial verdict according to the law and the evidence submitted to the jury at the trial." *State v. Duerr* (1982), 8 Ohio App.3d 404, 457 N.E.2d 843, paragraph two of the syllabus.

{¶15} The record indicates Juror Allen Schwartz is employed as an administrator at Med Central Hospital, where Aiden was first taken on March 14, 2004. Several testifying physicians from Med Central testified at trial. One of them, Dr. Anthony Midkiff, was a work acquaintance of Schwartz. Upon being questioned by the court during voir dire, Schwartz stated that his acquaintance with Dr. Midkiff would not influence his judgment regarding the physician's testimony. Tr. I at 40. Schwartz also stated he could think of no reason that he would not want someone like himself on the jury, were he to be in appellant's place. Tr. I at 154-156. Schwartz also noted he was aware that appellant had filed a lawsuit against the hospital, but denied it would impact his jury service.[2] Tr. I at 155.

{¶16} The second instance cited by appellant centers on Juror Lindsey Smith. She indicated during voir dire that her children are seen by pediatrician Dr. Brad Olson, another Med Central physician, who had assisted in Aiden's care. Appellant suggests that Smith was dependent on Dr. Olson's expertise to treat her own children, and this would create concern in her mind were she to consider the possibility of Dr. Olson being mistaken in Aiden's treatment. Nonetheless, Smith stated that she would not treat Dr. Olson's testimony in a different manner than the other witnesses, and that she

---

[2] We note appellant's trial counsel did challenge Schwartz because of his knowledge of the lawsuit; however, the court overruled said challenge. Tr. I at 246-247.

would be objective in listening to Dr. Olson on the stand. Tr. I at 39-40. Smith indicated that she had seen a picture of Aiden, but that it would not affect her judgment, and she otherwise had not experienced any pre-trial publicity. Tr. I at 85-86.

{¶17} Having reviewed the pertinent voir dire portions of the trial transcript, we are unable to conclude the trial court would have abused its discretion in seating Jurors Schwartz and Smith, such that we find no violation of trial counsel's duty to appellant. *Duerr*; *Bradley*, supra. We therefore find no merit in appellant's ineffective assistance claims in regard to trial counsel's performance during voir dire.

Misconduct of Juror Smith

{¶18} Appellant next argues that trial counsel was ineffective for failing to object to the court's denial of a hearing on the allegation of juror misconduct by Juror Smith.

{¶19} Toward the end of the trial, the court obtained information that Smith had allegedly had conversations about the case with an individual named Shawn Berendt at her place of employment, Flex-Pak, Inc. When confronted by the trial judge, Smith repeatedly denied knowing anyone by that name. Tr. VIII at 1876. In response to further questioning, Smith stated she had only mentioned appellant's name at work, just one time. Tr. VIII at 1877. She denied making any statements concerning the evidence in the case. Id. Although the court thereafter allowed each side the opportunity to explore the conversation further, neither the prosecutor nor defense counsel chose to do so. About six months after the trial, appellant's counsel moved for a new trial on the alleged misconduct, which the court denied.

{¶20} "Conversations by a third person with a juror during the progress of a trial for the purpose of influencing the verdict may invalidate the verdict, but where there is

nothing in the record to demonstrate that the decision might have been influenced by such conversation, the refusal of the trial court to grant a new trial will not be disturbed." *State v. Hipkins* (1982), 69 Ohio St.2d 80, 83, 430 N.E.2d 943, citing *State v. Higgins* (1942), 70 Ohio App. 383, 41 N.E.2d 1022. Furthermore, as an appellate court reviewing a claim of ineffective assistance, we "must keep in mind that different trial counsel will often defend the same case in different manners." *State v. Samatar*, 152 Ohio App.3d 311, 787 N.E.2d 691, 2003-Ohio-1639, ¶ 88.

{¶21} Upon review of the record, we are unpersuaded that appellant was prejudiced by his trial counsel's performance, in regard to the issue of Juror Smith's third-party contact, to the degree that the outcome of the trial would be suspect. *Strickland*, supra.

{¶22} Appellants' sole Assignment of Error is therefore overruled.

{¶23} For the foregoing reasons, the judgment of the Court of Common Pleas, Richland County, Ohio, is affirmed.

By: Wise, J.

Gwin, P. J., and

Farmer, J., concur.

JUDGES

JWW/d 212

IN THE COURT OF APPEALS FOR RICHLAND COUNTY, OHIO
FIFTH APPELLATE DISTRICT

STATE OF OHIO	:	
Plaintiff-Appellee	:	
-vs-	:	JUDGMENT ENTRY
MATTHEW STEIN	:	
Defendant-Appellant	:	Case No. 05 CA 103

For the reasons stated in our accompanying Memorandum-Opinion, the judgment of the Court of Common Pleas of Richland County, Ohio, is affirmed.

Costs to appellant.

JUDGES

edCentral Health System + 335 Glessner Ave + Mansfield, Ohio 44903

ATIENT NAME: Stein, Aiden P.
ED.REC.NUMBER: 373422
CCOUNT NUMBER: 4241355
HYSICIAN: Anthony Midkiff, M.D.
DMISSION DATE: 03/15/2004

MANSFIELD HOSPITAL
EMERGENCY DEPARTMENT REPORT

EMERGENCY ROOM TRANSFER

HIEF COMPLAINT: Respiratory arrest.

ISTORY OF PRESENT ILLNESS: A 4 month-old who paramedics found with gonal respirations. Apparently they suctioned some clear fluids from he child. The patient was not cyanotic on their arrival. Apparently as being bottle fed, formula, coughed, gagged, and then started aving respiratory problems. Apparently CPR and rescue breaths given y neighbor.

nable to obtain any further history at this time.

n talking with the parents the child was close to full-term as far as hey know. No significant problems with the pregnancy. Mother states here was a question of some wheezing once before, but no other edical problems. The child has not had persistent vomiting. The hild has been feeding well and gaining weight according to parents.

EVIEW OF SYSTEMS: Apparently has been doing well until today when his episode of choking and respiratory distress occurred. The child bviously does not contribute to HPI or review of systems. nformation above is from parents and EMS who were present on the cene.

AST MEDICAL/PAST SURGICAL HISTORY: Significant for questionable istory of bronchospasm.

AMILY/SOCIAL HISTORY: The patient does live with parents. He was ith father today. Mother was at work.

EDICATIONS: No programmed home medications.

LLERGIES: No known drug allergies according to parents.

EXHIBIT #3

PHYSICAL EXAMINATION: This is a 4 month old child who does have an occasional effort at respiration, does seem to have movement of extremities intermittently. The pupils are 6 mm, sluggishly reactive. The child is breathing only 4 to 6 times a minute, but is pink. Good breath sounds bilaterally with bagging, using bag-valve mask although as some coarse rhonchi bilaterally. Temperature was 95, pulse was 121, respiratory rate listed at 6 on nursing assessment. However, with bagging it is 20. The child does have an IV in place, right scalp, site is clean, no swelling. I see no signs of trauma on Head, Eyes, Ears, Nose and Throat exam. The neck is supple. The trachea is midline. There is no jugular venous distention. Lungs do have symmetrical breath sounds bilaterally with bagging. Heart is regular rate and rhythm. I hear no evidence of any gallop, click, rub. No Kayman's crunch. Heart sounds appear normal. Abdomen slightly distended, but soft. I did hold bagging for a second. I was able to just put a little pressure on the abdomen and it is soft and then resumed bagging immediately again. Femoral pulses are symmetrical. Skin has good color and warmth. Capillary refill appears right at 2 seconds. I see no rash.

ED COURSE/PLAN OF CARE/MEDICAL DECISION MAKING:
At this time, I did decide to electively intubate the patient, however, when I went to take a look the patient has a good strong gag reflex. Arms came up and he gagged, but this was not enough to get the patient breathing any better. We continued bagging the patient. At this time, I did treat the patient with atropine, Norcuron, succinylcholine. ET tube was inserted under direct laryngoscopy, a #4 ET tube to 13 cm at the lip. Symmetrical breath sounds bilaterally with bagging. No borborygmi. Orogastric tube was in place. The abdomen is soft at this point, scaphoid.

The IV had to be restarted in the hand as during intubation process. At some point the IV in the scalp blew.

I did actually treat the patient with a second dose of succinylcholine to intubate the patient. He did receive IV Ativan as well.

After the patient was intubated and tube placement confirmed I did treat the patient with Norcuron 1 mg IV.

Portable chest x-ray shows ET tube to be just above the carina, good aeration of lung fields. No infiltrate. No pneumothorax. Cardiac silhouette and mediastinum within normal limits. I did pull the ET tube back a centimeter.

I spoke with Akron Children's Hospital, Dr. Lee, in the Emergency Department. He accepts the patient in transfer. I then called Metro LifeFlight, spoke with them, and they did send a helicopter.

I called for an isolette to be brought down. I placed the patient in this under warming lights with blankets. I ordered a blood culture, an urinalysis. Treated the patient with Rocephin 500 mg IV, ampicillin 250 mg IV. I did ask for a second IV site, however, we were unable to find one. The nurse anesthetist actually came down as well and looked and could not find a second IV site. We do have one good line at this point so I left it alone. I did not feel that it was necessary to stick an interosseus line in when the patient does have a good line at this point.

Laboratory studies come back with a glucose at 293. I had done a fingerstick sugar which was 301. The BUN is 14, creatinine 0.5, sodium 136, potassium 4.2, chloride 103, CO2 15, anion gap is 18 which is elevated. The patient's urine showed a yellow, clear specimen. Negative leukocytosis esterase, negative nitrates, negative protein, but there is one gram per deciliter of glucose in the urine. Negative ketones. Moderate bacteria. Positive reducing substances. 40 to 60 fine granular casts. I asked for the urine to be sent for culture. The patient's hemoglobin was 11.1, hematocrit 32.6, platelets 283,000. The white count is still pending.

high glucose?

I did speak at length a physician on the Metro Lifeflight on his arrival. I was with him in the room during assessment and helped him move the patient over and get him ready for transfer. I did call the pharmacy, spoke with Scott, who very quickly got us the antibiotics when they were needed. I did go over risks and benefits of transfer with mother and father. I explained to them that Aiden was not stable at this point, however, he needs to be transferred to a pediatric facility as we do not have any way to care for a 4 month-old who needs intensive care monitoring. Mother and father understand the risks and benefits and they did sign the consent form for transfer.

DIAGNOSIS:
- Acute respiratory failure requiring intubation.
- Hyperglycemia, rule out diabetes mellitus.
- Metabolic acidosis secondary to #2.
- Urinary tract infection.

PATIENT NAME: Stein, Aiden P.
PHYSICIAN: Anthony Midkiff, M.D.
MED.REC.NUMBER: 373422
PAGE 4

ACCOUNT NUMBER: 4241355
EMERGENCY DEPARTMENT REPORT

ADDENDUM

The patient was critically ill here in the Emergency Department and required multiple reassessments, discussion with specialists, Akron Children's Hospital, discussion with the physician on Metro LifeFlight and with parents, multiple reassessments. I did reexamine this child's lungs every 4 or 5 minutes to make sure the tube had not shifted, that he still had good breath sounds. I reexamined capillary refill to make sure that he was still having good perfusion every 3 to minutes and I spent a lot of time at the bedside. Reexamined the patient as well as with parents and I did spend at least one hour of critical care time with this patient and this is in addition to time spent intubating the patient.

Anthony Midkiff, M.D.

M/vjl
D: 03/15/2004
T: 03/15/2004
c: Akron Children's Hospital

Authenticated by Dr. ANTHONY J. MIDKIFF On 3/15/2004 5:16:11 PM

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THEREUPON, the attorneys approached to read the questions posed by the jury and the following bench conference began.

MS. COUCH-PAGE: I don't know what that means.

MR. CASTOR: No objection.

MR. BOGGS: I don't either.

THEREUPON, the bench conference concluded.

THE COURT: Dr. Olson, I don't know if you can answer this question, but let me ask. What are some symptoms of low and high lung surfactant levels for newborns? Do you know what that question means?

THE WITNESS: Sure. The symptoms, gosh, you know, if it helps to give a quick analogy, when you've got a big canyon and you've got a train track and the trestle underneath, there's a lot of components to the trestle. When the train falls, nobody asks which component of the trestle collapsed, it's just the trestle collapsed. So when you have respiratory distress, there can be a lot of reasons to have respiratory distress, but what matters is treating the respiratory distress.

Surfactant is a chemical that comes out in the lungs and should be complete by 36 weeks.

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There's a component that comes out at 32 weeks and a component that comes out at 36. By 36 you would not expect surfactant to be a factor in respiratory distress.

THE COURT: What is lung surfactant?

THE WITNESS: It's a chemical, a chemical that the lungs produce. As a matter of fact, you produce more of it if the time around delivery is stressful.

THE COURT: Okay. If a baby incurred a birth-related brain bleed, what kind of physiological symptoms would be present during the first few months or weeks?

THE WITNESS: Well, you could -- again, the timing needs to be considered again. I'm the wrong guy to ask, but to my knowledge, you don't have birth-related brain bleeds after like 30, 32 weeks, it just doesn't happen. I may not be up on that literature, I leave that to a neonatologist. But again, anything that affects the brain can cause problems with anything the brain has control over. The respiratory centers are in the brain stem, sleeping, you know, there's a lot of electrical activity, you can have seizures. Muscle tone and strength all stem from the brain. Hearing, vision.

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Gosh, you name it. What couldn't you have?

THE COURT: Follow-on questions?

MR. CASTOR: No.

MR. BOGGS: No.

THE COURT: Thank you, Dr. Olson, you are done. We're going to take our break now, the last one of the day. We will come back in ten minutes.

THEREUPON, there was a brief recess.

THE COURT: Dr. Steiner, I think you are going to testify next. Would you come up here beside me, please. Please walk in front of the chair. She will swear you in before you sit down.

THEREUPON, the witness was duly sworn.

DIRECT EXAMINATION OF DR. RICHARD STEINER

BY MR. CASTOR:

Q State your name, please, for the record.

A My name is Richard Darryl Steiner, S-T-E-I-N-E-R.

Q And what is your business address?

A I work at Children's Hospital Medical Center of Akron, that is One Perkins Square, Akron, Ohio.

Q What is your business profession or occupation?

A I'm a pediatrician. I work in the emergency department at Akron Children's Hospital. I'm also the medical director of the care center, which is the

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clinic in the hospital that evaluates children that have alleged to be abused or neglected.

Q Can you tell the jury about what your formal education has been?

A I graduated from undergraduate school at Goshen College, Goshen, Indiana, and then spent four years in medical school at the Des Moines College of Osteopathic Medicine and Surgery. I graduated there in 1975. I did one year of internship at Cuyahoga Falls General Hospital, and three years of pediatric residency at Akron Children's Hospital. I then went into private practice, and was in private practice for eight years before returning to Children's Hospital in the emergency department. In 1991 I was given the directorship of the Care Center and have been in that position since 1991.

Q Do you have [illegible] it, within the [illegible]

A Yes. I have a [illegible] is pediatric e[illegible]

Q Are you Boar[illegible]

A Yes. I'm Boa[illegible] also sub-Boa[illegible] medicine.

Q Can you tell the jury what Board certification means?

EXHIBIT #4

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A Board certification is a recognition by the American Board of Pediatrics that acknowledges that a physician has successfully completed training in a series of examinations. The process is that you have to be trained in a residency program. You have to have experience in the practice. You have to take a written examination, and then a -- well, in my day, an oral examination to be Board certified in pediatrics.

To be sub-Board certified in pediatric emergency medicine, you have to have specialized training in that sub-Board of emergency medicine. You have to have experience in pediatric emergency medicine, taking care of kids who have been injured or ill, and then pass a written examination.

Q Have you also developed, for lack of a better term, I will call it, some subspecialty regarding child abuse?

A Yes. Since 1991 my continuing medical education has been within the discipline of evaluation of children that have been alleged to have been abused, both sexually abused, physically abused and neglected.

Q Do you belong to any professional organizations, and, if so, do you hold any or have you held any positions within them?

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A I am a member of the American Academy of Pediatrics, and within that organization the section on child abuse and neglect. I'm also a member of the Ohio Chapter of the American Academy of Pediatrics, and there I am a member of the committee on child abuse and neglect. I'm a member of APSAC, which is the American Professional Society on the Abuse of Children. I'm a member of the Rahey Helper's Society, which is a society of professionals that devote their professional careers to the clinical practice of child abuse evaluation.

Q And have you occupied any teaching positions?

A Yes. I am Assistant Clinical Professor of Pediatrics, and emergency medicine, pediatric emergency medicine at Northeast Ohio University, College of Medicine.

Q Is that located in Akron?

A Well, it's in Rootstown. It's an affiliation of the University of Akron, Youngstown State and Kent State University Medical School.

Q And have you had any publications?

A I have publication in a pediatric emergency medicine book on apnea, which is a -- means the problem of children who stop breathing. I also have published a lecture series on the abuse of children that have been abused.

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Q And have you also lectured at various places around the State and country?

A Yes. The lecture series took me around the nation, and also into Canada. I have also lectured in the region providing lectures to various hospitals and medical staffs. I lecture at the medical school. I lecture at our institution to residents, medical students, nursing staff. I provide lectures to law enforcement, to prosecutors, to Children Service workers on my role in evaluating children that have been alleged to have been abused.

Q Are you licensed to practice medicine?

A Yes, I am. I got my license to practice medicine in 1976, and have maintained that licensure in the State of Ohio since that time.

Q And have you previously qualified to testify as an expert in the area of child abuse?

A Yes. I have been qualified in each of the counties in northeast Ohio, with the exclusion of the lake shore county.

Q How many times, roughly, would you say you testify?

A I testify probably, oh, three or four times a month.

Q And for how long --

A Since 1991.

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Q Several hundreds of times?

A Yes.

MR. CASTOR: Your Honor, I would submit that Dr. Steiner is qualified to testify as an expert in the area of child abuse.

THE COURT: Proceed.

MR. CASTOR: Thank you.

Q Doctor, I'm going to ask a question that may take you a while to answer, but using, I believe, the doll that you brought with us, the model of the eye, which I have placed there in front of you, that I believe is labeled as State's Exhibit 9, the tablet we placed up there, would you describe what Shaken Baby Syndrome is, with or without impact, its causes, attributes and the basis for its diagnosis?

A Yes, that is a question that may take a little while to answer. But Shaken Baby Syndrome is a mechanism by which infants receive traumatic brain injury. Traumatic brain injury is really trauma that has force that has been directed toward a brain, an infant's brain, and causes brain injury. It's a mechanism where the head is whiplashed back and forth. The head moves in a whiplash manner back and forth. When it does so, the brain inside the skull is subject to the force of that whiplash, and is

banged against the inside of the skull, and as it does so it will deform and cause injury to the brain, the blood vessels of the brain, and cause the brain tissue to become injured and damaged, as well as bleeding to occur on the surface of the brain and within the brain. It is a particular devastating form of child abuse because it is -- injures the brain, and the brain in an infant, because of its structure and its development, will not recover. It won't -- those injuries are permanent, and the child loses potential, loses the ability to grow and develop normally.

There are other injuries besides the brain injury. There are associated injuries to the eye, to the retina of the eye, the back side of the eye. And I might use the model. I might use the model here of the eye to demonstrate that.

The eye itself is a hollow structure, and what I have in my hand is really the lining of the inside of the eye itself. This is the white part of the eye. Inside the eye is a lining called the retina. It is the back side of the eye that is damaged during this whiplash or shaking process. The reason it's damaged is that there is a gelatinous interior, a filler of the eye, called the vitreous,

that fits inside somewhat like this, and that clear jelly is adhered to the retina on the inside. And when the head is shaken back and forth, or the head whiplashes back and forth, this jelly compresses forward and backward, and as it does so it pulls the retina apart. That's what causes the retinal hemorrhage. The retina is damaged. The retina is pulled apart because of the deformity of the vitreous within the eye, and that causes the retinal hemorrhage, the pulling apart of the retina.

That occurs in approximately 80 percent of children that have been subjected to shaking. The brain injury occurs in all of these children. Retinal hemorrhages occur in about 80 percent of those children.

There are some other associated injuries, fractured ribs, because most of these children are held by the rib cage, and during the shaking process, there is gripping and compression to the rib cage, which will cause rib fractures. That occurs in about 60 percent of the cases. And in about 40 percent of the cases there are fractures to the arms and legs at the joints, and that's because the arms and legs whiplash back and forth and it can cause injury to the joint. Again, that's in about 40 percent of the

patients.

The mechanism of Shaken Baby Syndrome, as I said, involves a whiplash of the baby's head. That whiplash -- since you invited me to use the doll, I will demonstrate that. The whiplash, the baby's head goes back and forth like so (indicating) when this shaking is occurring. When it does that it pivots about a point, the point is at the shoulders or in the neck, and as it pivots, it sets up a peculiar and complex force within the brain that is called angular acceleration and deceleration.

Angular acceleration and deceleration is important because each part of the brain is moving at a different speed and in a different direction. Angular acceleration occurs, as you may be able to understand, when you play crack the whip on the frozen pond in the winter time. Somebody in the middle moves in a short arc and each person outside that, further away from that person, moves in a longer arc until the person way out at the end moves very, very rapidly. So each person moves at a different speed.

The same thing happens with the head in a whiplash manner. Each incremental distance from the pivot point moves farther and faster, farther and

faster as you move out. That causes a lot of torque and shearing force within the brain and causes the injury to the brain.

What happens is very much like taking a bowl of jello and shaking it. If you shake it a little bit, it will separate from the sides of the bowl. If you shake it a lot, the jello will crack. And if you shake it very hard, the jello will liquefy. It's the same principle as what goes on inside the baby's skull when its being shaken.

We have an understanding of how these babies are shaken, mostly from confessions by those who have shaken babies. We don't go up in the nursery and take a baby and shake it and see what happens, but we have received information from those who have confessed to shaking, and we have an understanding of how this occurred. Our understanding is that babies are grasped on the chest or thorax or trunk and then shaken violently. To do that, when that happens, the baby's head will whiplash. Sometimes the babies are grabbed like this (indicating), sometimes they may be grabbed like this, sometimes down here, but they are grabbed and then shaken violently.

Now, what I will do to demonstrate the violence of this and how it is easy to see how babies

are injured. What I am going to do is to shake this doll so that you can recognize how violent this is and how the baby will be injured. This is simply a representation of our understanding of how these babies are shaken. They are grasped -- and allow me to stand a minute -- they are grasped, held tightly and then shaken violently (indicating). And when that happens, it's apparent to anybody that a baby would be seriously injured.

Q Thank you. You indicated, I believe, in 60 percent that there would be damage to the chest, or 80 percent?

A Damage to the chest, 60 percent.

Q So that means four out of ten times there would be no bruising or broken ribs, that sort of thing?

A Correct.

Q Are there predisposing factors that have been found to a child suffering Shaken Baby?

A Yes. There are predisposing factors, and the biggest one is size. Babies are small, and so when an adult, who is a 150 pound adult, is ten times the size of an infant, and when a 150 pound adult or someone larger that than, picks up a baby and shakes it, you have that great size and strength discrepancy that predisposes the baby to be injured.

Secondly, as I mentioned before, the developing brain is prone to injury because of its development. And the baby's skeleton, also, is in the stage of immaturity which allows for these injuries to occur.

This type of thing is not limited, however, to infants. We have had children as old as three years of age be shaken, and there is at least one case of an adult suffering the injuries of a Shaken Baby Syndrome where two adults shook a prisoner and caused that to occur. So there's a size discrepancy by far -- size and strength discrepancy are by far and away the most important predisposition.

Q What about neck injuries in babies diagnosed with Shaken Baby Syndrome?

A Neck injuries do occur, although not very commonly. And the reason for that is that the baby's neck serves as a passive hinge. The baby's neck is weak, and so it doesn't resist the shaking and just acts as a passive pivot point for the baby's head. The baby's head is also large, and that -- and because it's large, it serves as a protective mechanism for the neck. As the baby's head goes backs, the large back of the head and the large occiput hits on the back and prevents a hyper-extension or an

over-extension of the neck. And the baby's chin likewise serves as a stop on the front to keep the baby's head from bending too far forward. So the baby's neck just pivots, but does not suffer injury.

As I said, there are some babies who do suffer neck injuries. Those babies are very seriously injured, and almost always die as a result of the injury of the shaking.

Q A two-part question -- well, no, never mind. Just one to start with.

Does the diagnosis of Shaken Baby involve ruling out other causes?

A Oh, absolutely.

Q Can you explain that, please?

A Yes. When a child comes to us, the child presents to us with a life-threatening condition, a serious health crisis. And we begin to evaluate that child to find out why. And as we do that, we begin to eliminate causes for that life-threatening event, that life crisis.

Often times we will do a CT Scan, and we will see bleeding on the CT Scan. The CT Scan, as it shows bleeding, tells us that there has been trauma. We then begin to eliminate accidental causes of trauma. We begin to eliminate any congenital

anomalies that could cause bleeding on the brain, and bleeding conditions, blood clotting conditions. Once we have eliminated all those other causes of what might be seen on the CT Scan, the bleeding on the CT Scan, the brain injury and swelling on the CT Scan, then we are left with the only diagnosis, and that is that the child has suffered abusive brain injury as a result of the shaking event.

Q I forgot to ask this before, how does impact factor into Shaken Baby?

A Impact can occur in the Shaken Baby Syndrome, babies that are shaken are often thrown following the shaking. Often times their head impacts on a surface, either a hard surface or a soft surface, and what that impact does is multiply the traumatic forces delivered to the brain.

As you might expect, as the baby is being shaken repeatedly, repeatedly back and forth, there's a momentum that builds up within the brain as it moves around. Then when it suddenly stops with an impact, the forces are highly magnified and greater injury occurs with the impact. Babies who have impact injury are more seriously injured and suffer more extensive sequelae and death.

Q That happens both with impacts on solid surfaces and

impacts on soft surfaces?
A Correct. It's the sudden cessation of that movement that is going on that causes the multiplication of the force.
Q You are talking about injuries inside the skull, not to the outside of the skull?
A That's right. This is to the brain itself, right.
Q Is Shaken Baby Syndrome or Shaken Baby Impact Syndrome a scientifically recognized diagnosis?
A Yes. It is recognized. There is a tremendous amount of literature in pediatric journals and pediatric textbooks that diagnose this particular syndrome, and identify its characteristics.
Q Is there any, in your opinion, serious dispute over the existence of Shaken Baby Syndrome?
A No. There is no serious dispute over its existence. It's a well-recognized diagnosis and syndrome among the medical profession.
Q Thank you.
MR. CASTOR: Your Honor, at this point, I would move into the questions about Dr. Steiner's treatment of Aiden. It's going to take a considerable amount of time. Perhaps would it be more convenient for the jury's understanding --
THE COURT: If you would prefer to

conclude now, or use the last ten minutes, either way is fine with me.
MR. CASTOR: Rather than break just after he gets started, we will probably have to repeat that again on Tuesday. And he will be back Tuesday afternoon.
THE COURT: We will pick up his testimony then again on Tuesday.
MR. CASTOR: Thank you.
THE COURT: Folks, at this time we're going to conclude for the day. I am going to send yo home. I have a couple of things to say to you. Remember your instructions not to discuss the case. You've only heard part of it. Remember your instructions not to pay any attention to media coverage of the case, newspapers, TV, radio. Again, you can have somebody cut those out or videotape those things, you can see afterwards if they got it right, but you have been here for the whole trial.
We will see you back here on Tuesday. We will try to start promptly at nine. Please leave your pads and buttons back there on the table. We will lock the jury room while you are gone.
THEREUPON, court adjourned for the day.

CERTIFICATE

STATE OF OHIO)
) ss.
COUNTY OF ASHLAND)

I, Linda K. Vozar, Stenotype Reporter and Notary Public within and for the State aforesaid, duly commissioned and qualified, do hereby certify that the foregoing, consisting of 246 pages, was taken by me in stenotype and was reduced to writing by me by means of Computer-Aided Transcription; that the foregoing is a true and complete transcript, to the best of my ability, of the proceedings held in that courtroom on the 26th day of August, 2005 before the Honorable James DeWeese. I also further certify that I was personally present in the courtroom during all of the proceedings.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at West Salem, Ohio this 2nd day of July, 2006.

Linda K. Vozar
Notary Public
3195 Manzanita Drive
West Salem, OH 44287

My commission expires 12/26/10.

MEMO TO: The File

FROM: Jim Gutbrod

DATE: March 3, 2005

SUBJECT: Aiden Stein

I met with Dr. Carl Martino, a neuroradiologist at Akron General Medical Center on March 2, 2005. I provided to him the copies of the CT scans of Aiden Stein's brain and skull from March 15, March 16, March 17 and March 22, 2004 along with the plain films of the skull from March 22, 2004. Aiden Stein was born on October 27, 2003. According to his mother Arica, Aiden was born not breathing at all, and had a blue color. He also was not moving and was taken to the isolette and had a 36% oxygen level. He did not move at all, was not crying, eyes were bulging. He failed a hearing test; his oxygen level was low for 1 and ½ days. At one month of age or less he had a dramatic increase in his head circumference.

On an ER visit on February 18, 2004 Aiden had a swollen toe and blood spots in both eyes, which was diagnosed as subconjunctival hemorrhage, which eventually cleared in a week or so. There was also an instance where Aiden rolled off the couch and hit his head on a coffee table and he had a bruise or lump on his forehead. There was not fussing or crying and he took food okay. Then in another instance his babysitter was holding him up over her head and his head contacted the globe of the ceiling fan.

On March 15 about 6:45 a.m. ~~Mathew Stein~~ Arica heard Aiden crying, went and got him and put him in the car seat and gave him a bottle, changed his diaper and his clothes. Mathew then put him on the floor, used the bathroom and came back out and put him in the bedroom. About 10 a.m. Aiden was crying and Matt Stein made him a bottle. He quit crying and went back to sleep and then woke up. His eyes were red, glassy, bloodshot and he put him in the basinet and he was coughing and fussing. He then was coughing and choking, went limp and was not breathing. Aiden began to turn blue and became motionless. Matt picked him up and ran down the hall and CPR was done by a neighbor, 911 was called, an ambulance arrived 5 minutes later and Matt rode with Aiden to Med Central. It did not appear that he was breathing until he got to the hospital. They immediately put a tube down his throat and there is a question whether they x-rayed to see the placement of the tube. It appears that the tube was not placed properly and was essentially in the right bronchus. They tried to put an IV in his head and according to the clients the "IV blew". He was at Med Central for 2 hours and life flighted to Children's Hospital Medical Center of Akron. They were bagging him the whole way up there. They took him to do the first CT scan. Dr. Steiner came and the CT scan was done. Aiden had hemorrhaging in his head. They said he had shaken baby syndrome, they were blaming his father Matt Stein and said that he would probably die.

The review by Dr. Martino of the March 15 CT scan showed an acute hemorrhage in the subarachnoid and subdural space on the left, with a small amount on the right.

EXHIBIT #5

Therefore, he would describe it as bilateral subarachnoid, a medium amount of subdural on the left, all acute. In addition, there was extraaxial fluid bilaterally. He did not known if it was due to old blood or due to atrophy of the brain with space taken up by the brain. He did say it could be due to previous blood which had been resorbed and replaced by serous material. The overall size of the brain in this CT scan is small, with approximately 10% decrease in size. (one small half of Normal)

The CT scan of March 16 showed a significantly greater subdural hematoma on the left side much greater than the right side, but now the right side also. A drain had been put in some time between March 15th and March 16th. This scan shows much less extraaxial fluid and the space that had been taken up by that fluid is now filled by brain. There had been fluid removed via the drain on the right side. There was more blood there. It appears that perhaps there are two drains one on the left and one on the right with the one on the left not having drained as fast. There is more blood accumulated on the left, now blood filling up the space where the fluid was on the left. Most likely there is more blood as a result of the draining of the extraaxial fluid. The review of the CT scan on the 16th strengthens the theory that the brain was small on the 15th because the fluid had squeezed the brain. Once the fluid was removed, the brain expanded. This lends credence to the idea that the fluid was there as a result of old blood. He would give the age of the blood as greater than one month and as much as six months or even the blood could have been there *in utero*.

The CT scan of March 17, 2004 indicates that the blood is less. The subdural hemorrhage on the left side is less than on March 16th. This indicates that it may have been drained. There is a tiny amount of blood on the right.

The CT scan on March 22 is striking insofar as it appears that Aiden has stroked out, lost blood supply. There is a new hemorrhage in the right cerebral hemisphere, the brain tissue is lower in density, as if Aiden had had a massive adult-like stroke. This condition is so severe that it appears that at this point Aiden is living on his brain stem. There is no more brain. It was probably caused by the brain being bathed in blood causing the vessels to go into spasm. Dr. Martino would say this with 90% certainty. It appears to him that the brain is dead. He said that one would want to do a flow scan of the brain.

The scan on March 15th demonstrates the brain is still perfused and normal, though small. The viability of the brain tissue gave out between March 17th and March 22nd. They tried to relieve it with the drains but got a bad result. While the CT scans could be consistent with shaken baby syndrome that is not the only explanation. It is possible that the bleeding could be ongoing. Once you have a big fluid collection around the brain this stretches the veins which could easily lead to ripping one of them.

I asked Dr. Martino about the misplacement of the endotracheal tube. He did not see how that could lead to acute subdural hemorrhaging, but he did think that it could affect the brain cells causing ischemia of the brain which could have lead to the end result of the infarct. I asked him if what he saw on the CT scan could have been caused by birth

and he said that he thought that it could. He explained that when you have fluid outside the brain, called hygroma, once again this stretches the bridging veins and any minor thing could cause a tear of these veins and thus a subdural hematoma. Even a minor trauma such as jostling could do this.

We then reviewed the plain skull films and compared those with the CT scans of the skull. Dr. Martino stated that he could with a 100% certainty say that there was no right parietal bone fracture.

Dr. Martino said that he would be willing to be involved in the case and write a report or give deposition but would not be interested in going to trial.

IN THE COURT OF COMMON PLEAS OF RICHLAND COUNTY, OHIO

STATE OF OHIO :

Plaintiff :

:

-vs- : No. 2005-CR-224

:

MATTHEW STEIN :

Defendant :

- - - - -

HONORABLE JAMES DEWEESE,

Presiding

- - - - -

TRANSCRIPT OF TRIAL PROCEEDINGS

- - - - -

SEPTEMBER 6, 2005

VOLUME VII

- - - - -

APPEARANCES:

ROBERT CASTOR, FIRST ASSISTANT PROSECUTOR
BAMBI COUCH-PAGE, ASSISTANT PROSECUTOR

On behalf of the State of Ohio.

KENNETH BOGGS, ESQUIRE

On behalf of the Defendant.

- - - - -

THEREUPON, the Pledge of Allegiance was recited.

THE COURT: Once again, I am glad to see there is still fourteen of you. The weather is nice. I know it is hard to come in, but we're back today to hear the final witnesses in the case. And we're going to start hearing the defendant's medical expert, Dr. Byrne.

Dr. Byrne, would you come to the stand, please, and we will have you sworn in.

THEREUPON, the witness was duly sworn.

MR. BOGGS: Good morning, Dr. Byrne.

THE WITNESS: Good morning.

DIRECT EXAMINATION OF DR. PAUL BYRNE

BY MR. BOGGS:

Q Could you state your full name and address, please?

A I'm Dr. Paul Byrne. Our home is at 577 Bridgewater Drive in Oregon, Ohio.

Q And could you tell us something about your education, like where you went to college and medical school?

A Yes. I went to Xavier University in Cincinnati, Ohio. And then I went to medical school at St. Louis University in St. Louis, Missouri.

Q And when did you get your license to practice?

A I got my license to practice -- my first license in

1957, and I have been licensed to practice since that time.

Q Where did you do your residency?

A I did my residency at the St. Louis University Group of Hospitals, which included the Cardinal Glennon Memorial Hospital for children.

Q And did you do any postgraduate work?

A Yes, I did. I studied the care of premature newborn infants at the University of Colorado, and also in Boston.

Q And are you Board certified in any specialties?

A Yes, I am.

Q Can you tell us which ones?

A I am Board certified in pediatrics, and I am Board certified in neonatal, perinatal medicine, which is neonatology.

Q And what is neonatology?

A Neonatology is the study, diagnosis, treatment and care of ill newborn infants, which includes premature infants and infants that are born with any kind of difficulty.

Q Have you had any academic appointments or taught in any medical schools?

A Yes. I have been on a faculty of medical school -- of a medical school since 1961. I started as an

instructor, and then worked my way up to where I was appointed as clinical professor of pediatrics at St. Louis University.

I held that same rank of clinical professor at Creighton University, and I was full professor of pediatrics at Oral Roberts University, where I was the director of neonatology and chairman of the department of pediatrics.

And, currently, my faculty appointment is a clinical professor of pediatrics at the Medical University of Ohio. They've recently changed the name from Medical College to Medical University of Ohio. And I'm director of the department of pediatrics at St. Charles Mercy Hospital in Oregon, and also a director of neonatology at that hospital.

Q And are you a member of any societies or committees?

A Yes. I'm a member of the American Medical Association. I'm a member of the American Academy of Pediatrics. And also a member of the Academy of Medicine in To

Q Have you writt ıg, sir?

A Yes, I have. I over the years publications. on

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problems with the nervous system in children as well as adults, and also with issues that have to do with ethics and related topics.

Q Have you written any books?

A Yes. A book on life support and death, and then I have chapters in books also for related topics.

Q Have you recently done any work with the --

THEREUPON, the Reporter cautioned Mr. Boggs to slow down and repeat the question.

MR. CASTOR: Object.

THE COURT: Are you talking about something related to medicine?

THE COURT: Yes, sir.

THE COURT: Overruled.

THEREUPON, the Reporter asked Mr. Boggs to repeat the question.

Q Have you recently done any work or a consultation with the Pope in the Catholic church?

A Yes.

THE COURT: Regarding medicine?

THE WITNESS: Yes.

THE COURT: Go ahead.

A I was invited by the Pontifical Academy of Sciences last February to give a presentation to them. I was one of twelve people from around the world who were

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invited to present on the topic of brain death and related topics. It was at the Pontifical Academy of Sciences.

Q And regarding the topic of brain death, you have written several articles, or co-authored several articles in several books, is that correct?

MR. CASTOR: Object, Your Honor.

THE COURT: Overruled.

THE COURT: You're talking in general -- you are trying to lay out his full professional qualifications?

MR. BOGGS: Yeah, Your Honor. I'm trying to shorten it from eight pages long.

THE COURT: I understand.

MR. BOGGS: I could read the whole thing.

Q Dr. Byrne, have you testified in any cases prior to this?

A Yes, I have.

Q Have you been qualified as an expert before?

A Yes, I have.

Q Can you tell us where and what cases you've talked about?

A I was qualified as an expert in the Baby Kay case, which was in Virginia, which went all the way to the

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Supreme Court. And I also testified in the Baby Tabitha case in Omaha, Nebraska, and that, too, I was qualified as an expert in both of those cases, and that one also went to the Supreme Court in the State of Nebraska.

Q So you have been qualified as an expert in at least two other jurisdictions?

A Yes, that's correct.

Q Have you also testified in this case in a different court and qualified as an expert there?

A Yes, I did.

Q And where was that at?

A That was in Akron, Ohio in the Probate Court. Oh, I'm sorry, sir, I also -- I don't know that I was qualified as an expert, but I testified in the juvenile court hearing in Mansfield in this case.

MR. BOGGS: Your Honor, at this time I'd tender him as an expert in this case.

THE COURT: Being no objection, you can proceed.

Q Dr. Byrne, have you had a chance to review the medical records of Aiden Stein?

A Yes, I have.

Q And can you tell us what medical records you have reviewed?

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A I'm sorry, sir?

Q Can you tell us what medical records of Aiden Stein you have reviewed?

A Yes. I reviewed the medical records of Aiden Stein at -- from Akron Children's Hospital, at least for the first several weeks that he was there. Those were all the medical records that I have been presented with from there.

I have reviewed the medical records from the emergency room at Mansfield Hospital. Also, the medical records from the birth of Aiden, and the medical records from the well baby clinic. I call it the well baby clinic, where he went to get evaluation for the feedings and immunizations and the like.

Q I'm going to have you refer to some records here, which would be State's Exhibit 16-A, which is his birth records.

MR. BOGGS: May I approach, Your Honor?

THE COURT: Go ahead.

Q Can you just skim through those real quick, Doctor. After reviewing those records, Doctor, can you look at the October 27, 2003, the notation at 0225 time?

A Yes.

Q It says in those records that stimulation was given, he was slow to cry. Oxygen per mask was given. Bulb

suction for moist breath sounds. Eyes are bulging. Slight tone of extremities, and his color is pale. What does that tell us as a physician, within reasonable degree of medical certainty, of Aiden's condition at that time?

A That tells us that the baby is in some kind of difficulty, that the baby is pale, needing stimulation to breathe, and also being given oxygen by the nurse because of her concern with the condition of the infant.

Q Now, it says oxygen per mask, does that mean -- is that significant?

A Well, we put a mask in front of the baby's face and give the oxygen that way.

Q And at 0230, eyes appear to roll back in the head. Color remains pale. Cries only to stimulation. Does that raise any additional concerns, from a medical standpoint?

MR. CASTOR: Excuse me, I didn't understand.

THE COURT: Would you ask the question again, please?

MR. BOGGS: Sure.

Q Eyes appear to roll back into head. Color remains pale. Cries only with stimulation. Does that raise

any medical concerns or considerations?

A Yes. That's five minutes after delivery, and the nurse is still concerned that he's not focusing, he's not crying normally, requiring stimulation to cry, and he's still pale. And so the nurse is concerned about the baby at that time.

Q Look at 0240. Baby arrived in nursery. Baby not crying. And tone slightly floppy. What does that mean medically?

A Well, that means that fifteen minutes after delivery, the baby is still in some kind of difficulty.

Q And it says color is pale and cyanotic. Now, that cyanotic is a new term. Does that mean he's turning blue?

A Yes, that means the baby is blue. In order to have cyanosis, you have to have five grams percent reduced hemoglobin is what makes the cyanosis, and so it tells you that the baby isn't able to get oxygen in all of the hemoglobin, so the baby is blue. It's not a good thing for babies or for any of us to be blue.

Q And that's even with the oxygen per mask, is that correct?

A Yeah, the oxygen will hopefully help that. That's the reason we give the oxygen.

Q And he was given five liters per mask?

A Yes. The five liters tells how much flow there is.

Q Pulse ox is 90 percent. Heart rate 160. Respiratory rate is 80. What does that tell us, from a medical standpoint?

A The pulse ox is low. The pulse ox is a measure of oxygen in the blood. Cyanosis is a measure of the carbon dioxide. Too much carbon dioxide, the pulse ox is low, it's 90 percent. There is not as much oxygen. If we did the pulse ox on all of us now, it would be 95 or 98 percent, at least, in all of us ordinarily. But even with the oxygen, the pulse ox was still low in Aiden at that time.

Q What is a pulse ox level that would raise some concern by the doctors?

A Well, we would, at least in the babies that we treat, ordinarily we try to keep them above 95. When you get down around 92, they will tolerate it okay, but below that, you don't want that to happen. You want to get the oxygen up from that.

Q At 0243 it says suprasternal retractions and nasal flaring. The pulse ox is still at 90 percent.

A Yeah. That tells you that the baby is still in trouble. The retraction is when we breathe in, our chest moves out, our diaphragm moves down, and the air goes in and follows that. Well, in a little baby

who is in trouble, attempts to breathe in, but can't get the air in, and so the chest is weak and it retracts in. And then the flaring, the nose flares, and it's another manifestation of respiratory difficulty in the newborn baby.

Q So he's having trouble breathing?

A Yes.

Q Stimulate baby to cry. Lungs slightly congested.

A Still, you know, another problem that the baby has. Little babies can only show their difficulty, wherever it is, in certain ways. And one of them, no matter where the problem is, whether it's in their lungs or their heart or their brain or their kidneys, they manifest with difficulty with breathing. And so it tells you that something is wrong, it doesn't tell you exactly what is wrong, but it tells you that if you give some oxygen, at least you can keep the baby oxygenated during that time.

Q At 0247 it says weight done with oxygen mask on face. Is that normal?

A I got to follow you just a second. Oh, at 2:47 is that where you are?

Q Yes.

A I lost the place. What --

Q Weight done with oxygen mask --

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A. Oh, yeah, weight done with the mask on, okay. Here's what happens, parents always want to know how much the baby weighs, that's the first thing they ask. So we get the baby weighed as soon as we can because we know they're all going to ask. But the baby is still in trouble, so the nurse put the baby on the scale, but put the mask there to keep the oxygen going so that the baby doesn't get into difficulty -- further difficulty while the baby is being weighed.

Q. Baby's color is pale, but not cyanotic. So has he improved slightly?

A. Yes, he has improved, and the pulse ox has come up at that time, but no longer is the baby cyanotic, indicating that more of the hemoglobin is being oxygenated.

Q. Okay. Now, you said in the same note there, they have the weight at thirty-one hundred and eighteen grams, the length at 43.9 centimeters, and HC, is that the head circumference at 33.7 centimeters?

A. Yes.

Q. Or 13 and a quarter inches, roughly?

A. I think you are getting that from a different page, correct?

Q. Yes.

A. Yes, right. And once the nurse measures the head

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circumference, and the length and the weight, then what we do is plot them on a growth grid, and the nurse did that, I assume she's a she, but I don't really know that. It's signed with an initial. But, in any event, the nurse plotted the head circumference, the weight and the length. And all of them were right at the 50th percentile or below that percentile.

The mean, the average of all of us, is right at the 50th percentile. Those that are smaller or shorter are below the 50th percentile. Those that are higher or longer are above the 50th percentile.

At birth, Aiden's weight, height, and head circumference were either right at the 50th percentile or below the 50th percentile.

Q. Let's go down to 0305.

A. Okay. I have 0300 in the column, and 0310.

Q. Let's go to 0300. Pale, pink, eyes appear bulgy with edematous eyelids or swelling.

A. I have to get on the correct page, okay. Eyes appear bulgy with edematous eyelids, yes.

Q. Is that unusual or is that common?

A. I think that we see that, but we pay attention to it because -- excuse me, because when the eyes are bulgy and edematous, sometimes it's a manifestation of

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pressure on that part of the head when the baby is being born.

Q. 0305, Vitamin K was given?

A. Yes.

Q. That's forty minutes after delivery. Is that common?

A. Well, we try to give the Vitamin K as soon as we can, and that's about fifteen minutes after delivery. All babies are born with a tendency to bleed. In the old days, they didn't circumcise the boys until eight days because they knew if they did it before that they would bleed.

When I was a younger physician, we didn't have any Vitamin K to counteract that, so we still paid attention to that. But then during the time that I have been a physician we got Vitamin K first as a preparation we can give in the muscle, later in the vein, and it helps a lot to correct the bleeding problems that all babies have. They all have a tendency to bleed, but we now give it to all babies.

If you don't give it, every now and then a baby will literally bleed to death. Before we had the Vitamin K, they would get the GI hemorrhage. If their liver got a little tear in it, they would bleed to death. Anything in the brain, wherever it is, they would keep on bleeding. But the Vitamin K

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changes that, and so we give it to every baby now, and it stops things.

This baby had the bleeding tendency until fifteen minutes after birth, and then the Vitamin K was given, and then that helps the blood clotting at that time.

Q. Now, 0310, Dr. Olson was called by the nurse, and he responded, ordered some oxygen, CBC and a blood culture. Is that medically significant?

A. Well, that's very significant because it tells you that ten after three in the morning -- morning, middle of night, depending on how you look at it -- the nurse was still concerned enough about Baby Aiden that she called Dr. Olson to relate to him the condition of the baby. His response was to get a blood count and a blood culture, and continue to give the oxygen, which is the general things that we do. Because, remember, that when a baby has trouble with breathing, we can't really tell what the problem is. It's the way it's manifest. They don't come with tags. They can't communicate saying my head hurts, my belly hurts, or whatever it is. And so we have certain things that we do, and one of the things we commonly do is get a blood culture, get a blood count, and we would continue the oxygen.

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Q Okay. Let's go down to 0420. Minimal crying during blood drawing. That's two hours, roughly, after birth.
A Yes. Babies, you know, we never like any baby to be hurt. On the other hand, if we draw blood on a baby and the baby doesn't respond at all or minimally, we get concerned about that because normally they don't like it to get their blood drawn. Sometimes we don't like to do it either. But they do cry normally. If they don't cry, they don't cry very much, we get concerned that there is something making the baby not respond in a normal fashion.
Q And then 0620 Dr. Olson called to check on the status on the infant. That's about three hours after he was called at home.
A Yes. If Dr. Olson is like other people that get called at 3:10, you give the orders, go back to sleep, and then when you wake up, you call in because you are concerned about the baby. That's what I see Dr. Olson doing at that time.
Q 0800, notation is pale, pink, slightly pale, eyes with some bulging.
A Yes. Still bulging of the eyes. The baby, all babies, essentially all, during the birth process, the head has pressure on it, at the eyes they can

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bulge, the head is molded. These are all things that happen to babies in the birth process. And many of you might have seen babies, recall that, and you recall sometimes they look like that, and they get better quickly, but we pay attention to it. Wherever the swelling or bulging is, it tells you that's where the pressure was.
Q You said you also looked at the medical records from the Health Clinic where he had his head measured and his vaccinations provided?
A Yes.
Q Let me hand them to you.
A I might -- well, anyway --
Q Look in the notation for November 24th.
A This one?
Q Yes. Shows his weight, length and head circumference.
A Yes.
Q Can you tell us what percentile he was in for the weight?
A Yes. He was below the 50th percentile, would be down around maybe the 35th percentile, somewhere in there.
Q How about the length?
A The length? The length is just a little bit lower, right around the 30th or 35th percentile.

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Q And how about his head circumference?
A His head circumference is beyond the 95th percentile, it's off the grid, probably beyond the 97th percentile.
Q And that's shortly within the first month of his life, isn't it?
A Yes, that's one month. Approximately one month after delivery his head circumference was out of proportion to his weight and length.
Q Does that cause you any concern as a physician?
A Absolutely.
Q Now, if Dr. Pope and Dr. Olson testified that they also would be concerned, what kind of concerns would they have?
A Well, our concern is at that time, is why is the head so big? We pay attention to that, and then we need to answer that question, why is the head so big? And so we -- I would be very concerned.
Q What kind of things would you do in response to that concern as a physician?
A Well, in modern times we have testing that we can do in terms of CAT Scans and MRIs and these things, give us images of what goes on inside the head. And so a baby that has a head that's too big like this, very likely skull films would be taken and a CAT Scan

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would be done. And then, if it would be indicated, further imaging in terms of MRI would be done.
Q And what kinds of things would you be looking for on an MRI or CAT Scan?
A Well, we have basic principles in medicine that we look for, and the more common one of them, one that's more common in the newborn baby is, is the baby's head made correctly? Is the inside of the head made, that is, is there an -- we use the word anomaly. Is there an abnormality of development of the brain or something inside.
Then once we get past the abnormality of development, then we have to think of tumors. Tumors aren't too common, but they do occur in newborns, so we think of tumor. And then we think of trauma, and, of course, all newborn babies have just gone through a traumatic event. It's difficult to be born. Mom's know that, and people who observe babies after birth know that it's tough to be born, and so we look for manifestations of trauma in a baby whose head is too big at one month of age.
Q Okay. Would you be looking at a CAT Scan or MRI for any subdural hematomas at that time?
A Yes. Subdural hematoma is one of the manifestations of trauma, but actually subdural hematomas, sometimes

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babies are born with subdural hematomas. They actually -- you know, modern times we have the ability to use ultrasound, and subdural hematomas have been found in the unborn baby, they are born with the abnormality. And, of course, when I was a younger physician, the way that we would have to look for subdural hematoma was that we would use needles in the soft spot, over the side, and very carefully look at that, and then if the head is subdural, we would get the fluid. Actually I brought a picture --

Q Can you show a diagram of what you are referring to?

A Yeah. I brought a picture from home because I know it might help to see how we used to do it.

The soft spot of the baby's head, everybody is aware of the soft spot, you go over to the side and get fluid out, and make the diagnosis of subdural. And I, as a younger physician, this is the way it was done. Modern times we use CAT Scans and neurosurgeons and the like. A neurosurgeon taught me how to do this. But we get the fluid out, and then we can analyze the fluid, because the fluid could be just cerebral spinal fluid, and it could be blood, but we would see blood. Or, if it's been there for a while, the red blood cells tend to disintegrate, and

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then you end up with something like serum, so it would be kind of a yellowish fluid. But we analyze it, and we look at the protein, and it's very dramatic, because the protein on subdural fluid is very high. That's how we could tell the difference, compared to spinal fluid, obviously you can tell blood because you can see it.

Q And you performed that procedure yourself?

A Yes. I have done it many times as a younger physician. I haven't done it for a long time because medicine changes, but it can still be done, but now the neurosurgeon does it.

Q If that procedure, or some procedure a neurosurgeon would do today, is not done, what is the outcome of the baby?

A Well, what happens is the subdural fluid, see, the dura is a covering around the brain. And subdural means under the dura, but there is really no space there. It all fits in tightly, and there is no space. But what happens that makes the subdural occur is that the blood vessels over the brain get stretched. And when they get stretched, they tear, and they leak a little bit of blood out. Then there is blood in the subdural space, but it's a space that doesn't have a blood supply, like if we get a bruise

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on our hand, it has a blood supply and the body cleans it up relatively quickly and takes care of that, but the subdural space has no blood supply.

So it has the blood in there that reacts, but what happens to it is that it becomes a dynamic fluid. Blood is leaking into it on a regular basis, and then it's being absorbed. Then what happens to the little baby, because the little baby has bones that aren't closed together yet, our bones are closed together, but newborn baby has the bones that are separated, and the baby gets along with that, sometimes pretty well. And the head can be too big, and but if it's not diagnosed, it can stay there for months. Although once it's there, it's abnormal, and then things can happen that will affect the pressure inside the head, that will affect the amount of blood that leaks into the subdural, and things go on like that. But they can go on for a long time with a subdural collection of fluid.

Q Now, if you are looking at a CAT Scan, how would the collection of subdural fluid look?

A Well, so far as the CAT Scan is concerned, it's an x-ray, but it's done with a computer. And then that basically gets slices of the head, and then you look at it. But the subdural would be at the outside,

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just underneath the skull. And what happens to blood when it gets in the subdural space on the CAT Scan, it shows up as white. And then over time, as it progresses, it tends to have the same density as the brain, so that maybe for the first week or so would be white, then as you go on for one to three weeks, it would have the same density of the brain. And sometimes you can't even see it, wouldn't even be able to see it so easily. But then once you get beyond three or four weeks, the red blood cells have been absorbed and then its fluid, it's very high in protein, but it has the appearance on the CAT Scan as being darker than the brain.

And so we use those, and we use the terms -- in terms of density, hyperdense in the brain meaning whiter than the brain; isodense, iso means the same as; and then hypodense, it's less white, it's blacker. So that's how the subdural fluid, we can determine the age of the subdural fluid when one looks at the CAT Scans.

Q I want you to have a look at Exhibits 8-A, B and C. In referencing State's Exhibit 8-A, B and C, it has on there head circumference charts. Are those similar charts, are they all comparing apples to apples?

A Yes, they are similar. There is a difference in them in the sense that -- actually this one, the way that we use it, has some colors in it, but the basic difference is that it is done statistically in standard deviation. And so this black line is the median or the middle, and then this dotted line is two standard deviations. And what happens, and statistically in one standard deviation, you get 68 percent of the population. Two standard deviations you get 95 percent of the population. So this is done in that way, so that really the midline is 50, but it's for a different reason. The dotted line would be five, theoretically five, but it's really 45 percent from the middle, so that's a little different.

Now, when you go to the one that was made in the well baby clinic, and the one done at the well baby clinic, and then the one by Dr. Steiner, the well baby clinic goes up to the 95th percentile. Dr. Steiner's graph has more lines on it, and it goes up to the 97th percentile, but, either way, they show the same thing. Where the chart that I showed you had the length and weight going right at the 50th percentile, as you can see those Xs, but you can see beyond, outside the 95th percentile is where the head

circumference was at one month of age. Dr. Steiner doesn't show that part. He just shows the head. But he shows that the head goes up at one month of age to about the 95th percentile. At three months of age, his graph still shows that it's beyond the 90th percentile, but it's out of proportion to weight and the length. It doesn't show you that part on this, that part is left blank, but they all show that the head is too big already at one month of age.

Q And Dr. Steiner's chart, I believe, is three years, yours is a one-year chart?

A I'm sorry, sir, what's your --

Q Dr. Steiner's chart, is it three years?

A Yeah. Dr. Steiner's goes to three years, and, of course, my chart, the one that I made, goes to twelve months. But it also shows what happens before birth, in terms of how these things go. But, you know, there are different people, some are very big, some are very small. So you have a graph for them, but they go together. The weight, length and head circumference go together for big people; go together for small people.

In Aiden's case, he was right in the middle at birth for all three of them. At one month of age his head circumference was way out of proportion,

depending on how you make that graph in terms of beyond the 95th percentile or 97th or 90th percentile, or whatever it is. No matter how you do it, his head was too big at one month of age.

Q Now, when they measured his head circumference, is there a standard way that the nurses are trained to do the measurements so that we all know what they are doing?

A Yes. The head circumference, you know, it's done with a tape measure, it goes around the head, and the standard anteriorly is the glabella. That glabella is this part of the anatomy that's between the eyebrows, but it's right here. Then we use the most prominent part of the occiput. The occiput is the back part of the head. The most common part of the occiput, so you get it in the back, just as far as you can, and then in the front where it is, and that's how head circumference is measured.

Q Okay. Now, Aiden had two visits to the emergency room, one in January 23rd and one in February 18th of '04. January 23rd, I believe, was for a cold; February 18th was for an eye problem.

Now, he's had a problem with his right eye from birth. Do you know what is causing that?

A Well, I can't say for sure. I have to be concerned

because his eye was bulging when he was born, and actually an ophthalmologist saw him when he was in the nursery shortly after birth, and so there is something there. Whether that has to do with obstruction of venous flow being manifest that way, or what he has, I can't say for sure.

Q Have you yourself seen Aiden since he has been born?

A Yes, I have.

Q When?

A I saw Aiden approximately April the 20th, 22nd, at Akron Children's Hospital. And I saw him again maybe about a month or six weeks ago.

When I saw him the first time, I examined him. I did not examine him when I saw him the second time.

Q When was it that you saw him the second time?

A About a month or six weeks ago.

Q Did he still have the droopy eyelid?

A Yes, he did.

Q The puffiness in the right eye?

A He did.

Q Is that unusual for a child to have that after almost two years?

A Yes, it is unusual. Obviously there is more to consider at this time than there was right at birth.

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Q Now, let's go to March 14th of '04. Testimony in this case has been that Aiden was with his grandmother earlier in the day, and that evening he went with his parents to visit another grandmother. They testified that he was crying and they couldn't get him to stop crying. He was turning red, holding his breath, and making a funny "eehh" sound. Would that raise any concern to you as a doctor?

A Well, babies do those things, as all of us that have been around babies know. They do cry, and sometimes it's difficult to console them. But if we're used to the baby, and we can usually console them, and then if we can't console them with our ordinary things we do, feeding, holding, rocking, and the like, then there is concern about what's the problem.

And, of course, the issue often with babies is they don't tell you, you know, my head hurts, my belly hurts, or whatever it is. So it's a general thing, but babies can only do so many things. When they are first born, they have to breathe, so we pay a lot of attention to that. Later on they have to eat, so we pay a lot of attention to how they eat. They cry, we pay a lot of attention to that.

So, yes, on March 14th Aiden could have been not able to be consoled, and somebody could have been

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paying attention to him at that time.

Q On March 15th around 10 to 10:25, the father notes that he's not breathing, he's turning blue, and he goes to seek help, takes him to the neighbor's. The neighbor starts performing CPR by tilting his head back and blowing in his mouth and nose. He says that he hears a funny noise in his chest, and he realized he didn't have a good airway, so he cleared out a lot of mucous. I believe he said he did that twice. The squad arrives, they clear out some formula, more mucous, and then they get him to the hospital at MedCentral.

Have you had a chance to look at the MedCentral records on March 15th?

A Yes, I have.

Q Dr. Midkiff was the treating physician for him there. And Dr. Midkiff says that he was not cyanotic on arrival, he was -- they were told he had some formula, he coughed, gagged and started having respiratory problems; noted there's some congestion; no signs of any physical injury or trauma; no redness, no swelling, no blood clots, no streaks, welts, no nothing. He did determine that he thought he had acute respiratory failure requiring intubation, and the records show, I believe, that he

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had to make four attempts to intubate the child.

Can you tell us what kind of procedure intubation is?

A Yes. Intubation is a procedure where we look in the throat, find the airway, and put a tube in there, endotracheal tube. They attempted that at Mansfield emergency room, and they were unable to get the tube in because Aiden was coughing and gagging and throwing his arms up and responding, rebelling against them, so they couldn't do it.

Eventually with -- they paralyzed him, gave him a drug so he couldn't respond anymore, gave him a tranquilizer-like drug, Ativan, to cut down on things. Gave two paralyzing agents, Succinylcholine and Vecuronium, and each one of these was another dose because Aiden was still responding.

What happens when you go to intubate a baby, it's moist, and you have to find the airway. Then you go to put it in and it slips off, especially if they respond and rebel. Sometimes babies that are about five months of age, or thereabouts, are the more difficult ones to intubate, because they are bigger, stronger, and they respond more in the like than newborns. But that's why they had to do that. Aiden was such that, yes, he was in trouble, but he

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wasn't in so much trouble that he couldn't respond to them, and they had to paralyze him to intubate him.

Q Do you recall from the records, did they have to pull the tube back?

A Yes. There are few notes on the record. One note is from the radiologist who noted that the endotracheal tube was too low, and he called the emergency room to tell them that and have them pull the tube back, but he makes note in his note that Aiden had already left the emergency room, and so he wasn't able to communicate that to anyone.

It's also noted somewhere in his chart that the endotracheal tube was pulled back one centimeter by Dr. Midkiff or someone at Mansfield emergency room.

Q Are you aware what happened to that tube once he got to Akron?

A Yes. And the fact of the matter is we can show the x-rays and show you exactly where the tube was too low at Mansfield, and then show that when he got to Akron Children's Hospital, that, again, was diagnosed as having the tube too low. The difference is that it had been too low long enough so that all of the air in the left side is absorbed so there is no air in the left lung. There is air only in the right

lung. He is being aerated by just the right lung at the time of his arrival at Akron Children's Hospital, which is about two hours after the first x-ray was taken.

MR. BOGGS: Your Honor, at this time I would like to set the box up and show the x-rays.

THE COURT: Sure. He comes fully equipped.

(Laughter).

THE WITNESS: Well, you get into these things.

Q Doctor, we have marked as State's Exhibit 24, that's a chest x-ray, that's what you are showing there?

A Yes.

Q Tell us what that shows you.

A This is the chest x-ray from Mansfield emergency room. And the time of this is 11:25. This white -- two white lines are the endotracheal tube, and someone has put a circle around that. This is a copy, I didn't put the circle around it, but I suspect that the physician at Mansfield put the circle around it. And shows the endotracheal tube down here. This is the left main stem bronchus. This is the right. So this goes to the right lung, this goes to the left lung. And it's down too far.

One of the common problems that we get into when we intubate, it tends to more easily go into the right side if we go down too far. So where we would like that tube to be is up about two centimeters higher, so that it's up here at the level of the clavicles or just below.

Q Can you show us the x-ray when he got to Akron?

A When he got to Akron Children's Hospital -- I will move this one back over a little bit so we can see them both together.

Akron Children's Hospital, you can compare the two, and still the endotracheal tube is just about the same position it was there, but it's too far, and you can see what occurs is just the right lung is being aerated, and the left lung, all the air that's in there gets absorbed because there is no more air to get in. And young children are a bit different from adults, but young children, the air can get absorbed and the lung collapses.

THE WITNESS: Are you able to see these?

MR. CASTOR: I'm fine.

A But, in any event, you can see what happens.

Q What clinical significance is the collapsed lung?

A Well, it's possible to keep them oxygenated because all of us have known someone that has had a whole

lung removed and they go on and live. So we're made with more lung than what we need for every day, we have reserve. So it's possible to keep them oxygenated.

What happens is when this lung collapses, that interferes with the circulation. And the way the circulation works, the blood that returns to the heart, goes to the right lung, goes to the lungs for oxygenation, gets rid of carbon dioxide, then comes over to the left heart and goes out to the rest of the body.

So what happens is that because of interference with the circulation coming through the chest at this time, the blood backs up, and it backs up in all of the veins, but especially in the veins of the head, because it's made without ballast, and so it backs up, and then that affects wherever it goes, including the cerebral circulation. So it backs up into the brain, and eventually backs up into the eyes.

So when you have this kind of situation, the baby is set up to have hemorrhage in the brain, if there's a weak place, to have hemorrhage. The eye vessels tend to be weak and has a tendency for those eye vessels to break. This is a significant thing.

There are a few other things on there. He has a tube that goes down into the stomach. The stomach is big here. Part of why it's big here is because they were using bag and mask to ventilate him before they were able to intubate him, trying to help him in that way, and the stomach gets way too big. The stomach is reduced a bit here. This is at 13:10, which is almost two hours after the first film.

Q So the oxygenation of the lung is not the same thing as venous pressure, is it?

A No, they're different. The lung to function, it's to get oxygen in, is to get carbon dioxide out, but to do that there has to be circulation and the circulation return is passive. You know, we have a pump, the heart that pumps it out. The return of the blood is passive, and if anything interferes with that circulation through the chest it backs up. And this is one of the examples, the chest compression, when they do that, to resuscitate, during the time that the chest is compressed, that backs up the blood in the veins that come from the head. And that's a problem that we have to pay attention to.

Q Do you recall looking at the Med Flight records?

A Yes.

Q Was there anything that was significant in the Med

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Flight records with regard to what you just testified to regarding the collapsed lung?

A Not that I recall. It seems to me that his -- he was oxygenated. They had him on supplemental oxygen, as far as I can tell, in route.

Q I'm going to hand you what has been marked as State's Exhibit 2. Can you look at those for a second, please?

Is there anything on the Med Flight record, on the initial assessment part, that you find to be striking?

A Well, it says that Aiden became apneic while being fed the bottle. And he was intubated. And before they intubate him they had given him Ativan, which is kind of like a paralyzing -- I mean, kind of like a tranquilizer -- Succinylcholine, they also gave antibiotics. And it says here, and also gave Vecuronium, which is another paralyzing agent.

His blood sugar was 310, you know, and his urine sugar was greater than a thousand, indicating that something was going on with his sugar metabolism at that time.

It says that his fontanel -- that's that soft spot I showed you the picture of. We pay a lot of attention to fontanels because sometimes they are

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depressed, sometimes they are straight across, and if there is pressure in there that's too much, it bulges out. So we pay a lot of attention to that, and they did, too. And they said fontanel non-depressed or bulging. So at the time he was in route, his fontanel was not depressed or bulging. His head was too big, but he was able to get along with that pressure still even at that time.

It says that the ET tube at 13 centimeters, 13 centimeters is the same note that they had at Mansfield Hospital. And then they had to come back two centimeters, that would make it 11 centimeters.

Q Now, the MedCentral records also note that there was nothing wrong with the fontanels at that time. But when is the first time, do you recall, that there was a problem with the fontanels on March 15th?

A Yes. After he was admitted to Akron Children's Hospital.

Q I believe the time on that would be around 1405?

A Yes. I would have to look it up to be sure.

Q And they pulled the tube back, according to the notation, around 1515 --

A Yes.

Q -- by two centimeters?

A Yeah. So, again -- did you say 1515?

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Q Uh huh.

A So even that, that's another two hours from the time this is here until it's pulled back, so.

Q And we notice that the blood sugar at MedCentral, before they transported, was also elevated. And when the squad arrived that morning, it was elevated. MedCentral had the blood sugar at 293. Is there a possibility this baby was diabetic?

A Well, at least for that time he would fit the diagnosis of diabetes. It doesn't fit the diagnosis of diabetes mellitus that we would think of at another time, but certainly he had higher sugar than what was good for him at that time. And he was spilling the sugar in the urine, which also -- any time the sugar gets over about 180, it goes out in the urine.

And the discrepancy, or the difference, in the 310, the 293, the 310 is what is done on finger stick. Many people take care of their diabetes at home with finger sticks. And if we a draw blood sample, there's a little difference. So there is a difference between 293 and 310, but not a lot, and there is some acceptance, accepted difference in the two, but it's two methods.

Q Now, would the trauma from being sick that morning

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and gagging and having trouble breathing raise his blood sugar?

A Well, something raised his blood sugar, and he really had that. I don't know for sure why his sugar went up. He was very sick at that time because he was coughing, gagging, not breathing, and during that time his blood sugar went up. So that's all I can say. It isn't normal, but I can't say other than that.

Q If the parents have testified that they fed the child Similac with a cereal rice, or whatever, with the formula, would that be improper?

A It's commonly done, and certainly the Similac is very common. The addition of rice cereal is done. I, myself, prefer not to encourage people to do that because you really don't need to.

In modern times the words Similac is similar. In modern times we can analyze the breast milk, know what's in it, and they make formulas to be as close to breast milk as we know how to do it. It's not exactly the same, but you don't really need supplementation for that. People do it, though, for all kinds of reasons. You can't fault them for it, but I, myself, I don't do it.

You're making me think. I can fault them a

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little bit because what happens is that, it's often done because the baby is a little bit irritable and that, and then when the rice is given, it's a processed cereal, and the outside of the grain is taken away, and the outside of the grain is where the magnesium is, and babies get deficient in magnesium when they get cereal. So that's another reason I don't do it.

If you look at my CV, it will probably tell that I've done some research with magnesium and newborn babies. So I tend not to give them rice cereal. They'll do fine with Similac, but I can't fault them for it.

Q Now, once he got to Akron and they got the tube pulled back and got the lung inflated, they also ran a CAT Scan of his skull. Did you get a chance to read those CAT Scans?

A Yes.

Q Could you show us what you see in the CAT Scans and tell us about it?

A Yes.

Q Dr. Byrne, you have the ones that have been marked State's Exhibits, which I think in this case is --

THE COURT: The six series, B through E. It looks like he has the same thing.

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MS. COUCH-PAGE: He doesn't have the ones that are marked.

MR. BOGGS: That's the only difference. They are not marked.

THE WITNESS: We can easily match it up. I can put the little marks on this side, in the right-hand corner, and put the date on.

MS. COUCH-PAGE: Those aren't the right ones --

THE COURT: While you are getting that sorted, why don't we take our morning break. We will come back in ten minutes.

THEREUPON, there was a brief recess.

THE COURT: Go ahead whenever you are ready.

BY MR. BOGGS:

Q Dr. Byrne, before we start looking at the CAT Scans of the brain and the head of Aiden, do you have any other model that would show us, in a three-dimensional approach, what we're talking about?

A Yes, I do.

Q Would you pull one out for us, please?

A I actually brought two. It's not easy to put all this together to make good sense out of it. In order to interpret these CAT Scans, I think it helps to at

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least look at a model of the brain.

They are not nice to look at, I guess, but, in any event, you get the idea, the large part of the brain, the cortex. This part that's green is the cerebellum, and these CAT Scans will be slices that come across this. Obviously the eyes are missing there, but I will show you where that fits in the whole thing.

And then this is another model that gives you the idea of the cortex being the large part of the brain, and then the cerebellum.

And this one, nicely, you can turn it around, and when you turn it around, you get what the brain looks like on the inside. I can take this one apart and show you, too, but for our purposes, it shows you the cortex, the ventricles or the fluid-filled space in there. And right up here under the skull are where the blood vessels are, much -- somewhat similar to like they are in this model. No model, no picture is exactly like it really is in real life, but it helps.

There really is nothing under the skull, except the coverings, and then the blood vessels are under there. And then when they make CAT Scans, they use with electronic gadgetry, can essentially make it

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like slices. Then you have to keep going from slice to slice.

This one happens to be that we can see the eyes. And if you look at the eyes, here you can see the lens of the right eye, and the lens of the left eye. I know it's right and left because this says L and that says right -- R, so we have to look at it like that. It's always hard sometimes, too, and one of the first things you learn in medical school is what's right and left and how to make it right and left on the patient, so you get used to this.

For our purposes, right eye, left eye. These slices come through the eye part, straight back, and then as you come across here, you keep going up higher. And I have another one here that shows it all the way to the top.

One of the things I want to show you is that here you see the lens of both eyes. Here you only see the lens of the right eye. You don't see the lens of the left eye. Why not? Because it's not straight across. So that always when you interpret radiographs of something the technician positions them as correctly as they can, but it won't be exactly the same, so that's there. So there's always a little difference in the two sides.

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But, anyway, as we come -- go up further from the eyes, up further, and these are millimeters differences, as you go up further, you see less and less of the eye. And the first thing you know, you get up into where the frontal part of the brain is.

In the front part of the brain, this is -- essentially the gray part is brain, and then this black part is the subdural collection of fluid. And that's very abnormal. That's not abnormal at all.

You can also see that this is in the front part. It extends off to the side, both sides, so this is a large subdural collection of fluid. It's not proper to call it a hematoma, although its started. Hematoma means blood. It started with leakage of blood, but the body is working on it all the time. The body is trying to get rid of it. It keeps forming.

Studies were done by the Japanese to show that there is a leakage into these on a regular basis. And then there can be an exaggerated leakage. But we can see the large part of this collection of fluid, it's subdural, and remember what I told you, is that it's darker than brain.

We use the brain to determine what we compare to, so when there is new blood -- and I will show you

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that on the next one -- it's white, and as we go up higher. But the large amount of fluid here is blacker than brain. It means its been there for longer than four weeks. We can't tell because the body can only do so much. So we have to say that it's longer than four weeks that that's been there. So the large subdural is chronic.

What's a chronic subdural? That's one that wasn't diagnosed. So it changes from the acute, the new, to one that is there for a longer time. This is a chronic subdural collection of a large amount of fluid.

Down here, you can see the ventricle, I showed you the fluid-filled compartment. It's actually blacker than this, but that's cerebral spinal fluid. If you analyze cerebral spinal fluid, the protein is about 45, cerebral spinal fluid, and that's what that would be there.

In subarachnoid fluid, as was measured and analyzed in Baby Aiden's case, was nineteen hundred and ninety-three. That is tremendous. That is clearly subdural fluid, is what they got out, and that fits this picture as a chronic subdural.

Now, if we keep making the slices, and, remember, this is a continuation of the one. So we

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keep going up higher on the brain, higher on the brain, but this is all around the brain. This is a massive subdural, massive chronic subdural. As we get up towards the surface, yes, there is this new blood, it's way up on the top of the head. It's localized here more on the left. There's a little bit that goes down here between, what we call the interhemispheric fissure down in that area, so it heads down there.

But you see this is the first CAT Scan that was done, and you see Baby Aiden's problem was chronic subdural, there for longer than a month. When we say month, it's because we can't tell how long. And then the new bleeding is new. All we can do is say that it's new. We can't tell whether it got there in the ambulance as he was going to Akron Children's. We can't tell if it got there in the ambulance as he was going to Mansfield. We can't tell if it got there before he ever left his home. All we can say is it's new, and that's all you can say. And, actually, the report says acute and chronic subdural, or possibly sub acute, they put that in there. If you don't go look at the films, you don't know what it is. You just read the report. You got to go look at it.

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Once you look at these films, you say, my goodness sakes, this thing has been there for a long time. And the big problem with Aiden is the chronic subdural, yes. He's in a serious problem that caused him to vomit, cough, choke at home, and the respiratory difficulty. But the acute problem is superimposed on the chronic problem that we see here.

Now, electronically, they do something different. I can show you these bones, and we already talked about the fontanel, the soft spot. A fontanel is where more than one bone comes together in the newborn baby. It happened to all of us a long time ago. A suture is where two bones come together.

So, normally, the baby has the soft spot in front, the fontanel, but it's made up of the coronal sutures come down each side; the frontal sutures, also known as the metopic that comes in the front; and then the sagittal suture goes down the middle. So the anterior fontanel is where those come together.

Well, coming down on the side, you can see here, this is the coronal suture. You can see the coronal suture on each side. When you get to the back, you can see the lamdoid, and you will see it better because this was electronically done to look

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at the brain and the subdural fluid.

Now, they changed the setting on the machine, it's the exact same test, but they changed the setting on the machine, and it's similar. You don't see the lens, although up here I can see the eyeball is there. So we start moving up. And, as you move up, now look what the coronal suture looks like? And you can see the coronal suture on each side.

And then the back, the posterior fontanel is where three bones come together, the parietal bone on each side, and the occipital bone in the back, and it's kind of triangular shaped, but when you do it on the CAT Scan you see coronal suture on each side. You see the lamdoid suture on each side. This is over on the right. It's a little different from the other side, but that has to do with how the slice is made. Nothing is like the real thing. It gives us some clue.

But these are called bone windows, and these bone windows, and this was interpreted as no fracture seen, and a little later on, we will look at another film, but I want you to keep in mind that the other film that gets looked at is the antiquated way of looking for fractures. I did it many times when I was a younger physician, all we had was skull films.

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We would get that and we would see things that we couldn't tell for sure. It still happens. We get the antiquated film, which is what they'll show you after about eight days, and then what do you do when you have an abnormal skull film? You get a CAT Scan. Well, they did the CAT Scan right away. When Aiden got in, he had no evidence of fracture. They even make note on the report, no evidence of fracture.

To continue on so that you get to see the rest of them. As you keep coming up, and you get -- this is all the way up at the very top of the head. This is actually probably the scalp as the slice is made, and then you start to see -- if it was straight across, they would look alike on the two sides. But as you come down, and this is the parietal bone, there is nothing in the parietal bone. Not only is there nothing in the parietal bone, but there is no swelling. We can see it easier if we hold it up to bright light and look for swelling, but there is no swelling.

If there's a fracture, something has to hit, traumatize to do it, and then just like any bone, if you've ever had a broken bone, it swells and bleeds. Fracture of the skull swells and bleeds.

Likewise, if we come back to this one, where

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we look at the sutures that we can see, what happens is if you have a fracture -- and they do fracture in the suture, you know, they can fracture in the middle of the bone, they can fracture in the suture -- you see bleeding. And the same as I showed you, the blood is white on there. It's white at a fracture, too. Thank God we don't see them too often, but about two weeks ago I saw a baby that shortly after birth, and had a fracture on one coronal suture, and on the lamdoid suture, and the blood leaks around there. You can see the blood on the x-ray. This baby has no blood. There is no acute fracture. And they correctly interpret it at that time.

Q In the CAT Scans, when you point out the lenses of the eye, will a CAT Scan show whether or not you have a retinal hemorrhage?

A I would say probably not. You would like to think that, but I doubt it. I've looked for them on this baby, and you got to remember that what they call hemorrhages in the eye are relatively small compared to the eye itself. And then the retina is the back of the eyeball, and I tried to see maybe some thickening, but I don't think you can call that on here.

Here you can see the optic nerve on the left

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side coming off there. But the optic nerve and the retina are actually developed as part of the brain, and the blood supply comes from that. The arterial blood supply, the venous blood supply goes right to the brain. It's all part of the brain, the back part of the eyeball there.

So what you see when you look in the eye, you get a reflection of what is going on in the brain. Maybe some of you have gone to the doctor and he uses the ophthalmoscope to look in the eye. People with glasses know that they look a little fancier, ophthalmoscopes. One of the things that we look for when we look at the back of the eyes, we look for hemorrhages. Now, little babies, it's a little more complicated, and we dilate the eyes and we use a little sophisticated -- a different technique, but we look in there for hemorrhages. We look for some swelling. But when we see hemorrhages and swelling, we are seeing a reflection of what is going on in the brain.

Q So, the one CAT Scan, I think it's 6-C?

A That one is 6-B. 6-C.

Q Yeah. Has different shading than what --

A Just a minute. Let me get it up here, please. Okay, go ahead, sir.

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Q In that one, do you see any skull fracture?
A Well, let me -- I have already reviewed it carefully, but I will review again. And the frontal bone, the coronal suture, the parietal bone, and, again -- now, remember, these are done for the brain, and the inside, they are not really done. The other ones are the bone windows. But I see no fracture on this.

I see coronal suture, you can see a split in it. You can see a split in it. And it's a little different from the other side, but, remember, it's at a little different level. It's a little different level. But it's a split, but it's a normal split. Babies normally have splits. Actually, I went to the anatomy laboratory, and I did bring a skull, it's in my car, but to show you the way these sutures are, and how they are when a baby is born, and then how they grow together. Ours are all sealed and solid. But newborn baby, those bones are separated because that's what they have to do to mold and change in position to get born.

I have seen a few babies over the years that those sutures close before birth, and they can't be born. They have to get delivered by section because the head has to mold, so it has to be open.

Well, then what happens in Baby Aiden is his

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sutures are delayed in closing because he's got extra pressure in his head. Since birth, he's had extra pressure in his head. Makes these sutures actually be a little more apparent. It's possible that if he didn't have that, we might not be seeing these sutures as distinctly as we see them there, but there is no evidence of fracture on this.

If we look at the bone window, which would be comparable to that 6-C, which would be done to look at the bones, again, coronal suture, coronal suture, you come down, coronal suture, lamdoid suture. See, these are made to show the bones, so you can see them better. It's the same slice as the other place. Here's the parietal bone, and it's on the left side where the question is. And you go slice after slice and you can't see a fracture anyplace, so.

Q In your review of the records at Akron Hospital, did you get a chance to look for any retinal scans?
A I did. When I went to the hospital, actually on the order sheet there are two places where the retina scan was ordered. And there is two places indicating where they were taken. So I asked for them, and they told me they couldn't find them. So I said take me to the department that does them, to the photography department or whatever department it was. I went

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down there, there were two people there, and I asked for them, and they started looking for them. After looking for them a little bit, they said they couldn't find them. So whatever the retina scans are, they weren't able to be found.

Is there an advantage to a retina scan?

Sure. If they took the picture of the retina, then we could all look at it. Same as they take a picture of the CAT Scan, you can all look at it. In some ways you can come to your own conclusion about what is blacker than whiter, and how big it is. In some ways you don't have to be a super-duper doctor to tell what this is once you have the picture. It's the same way with the retina scan. It could show what the hemorrhages are, if there are hemorrhages, or if there is not, it would show that.

For whatever reason, they can't find the retina scans. I'm very surprised. I wasn't surprised they couldn't find them when I went over there, but I'm very surprised they haven't turned up by now.

Q What significance would retinal scans have on retinal hemorrhages regarding in assisting and diagnosing Baby Aiden?
A Well, it's essentially a picture, but it shows a

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picture -- see, when the ophthalmologist looks in the eye, he's the only one that can say what's there. Or, anybody else can look in the eye, too, but there is only one person that can look at a time.

You take a picture of it, and now everybody can see what the retina looks like. And the retina is the part of the eye that we use for vision. Everybody can see what it looks like, and it has blood vessels. If I look in any one of our eyes with ophthalmoscope, I can see the arteries, I can see the veins, I can see where they come out of the optic disk, the optic nerve. I can see all that. And if they had a hemorrhage, had a break in it, I could see the hemorrhages. We are trained to look for those.

And so whenever we have a question of something wrong with the central nervous system, we always look at the retina. It's difficult to do in little babies. And you and me, we can say focus on the clock in the back and look at it and keep our eye steady, because every time you came in with a light you tend to close the eye and move away from the light, a normal and natural thing. So you have to kind of chase after the little baby to see it, but we look any time we suspect central nervous system problems.

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Q Dr. Malhotra, who is the ER Doc, did an examination of Baby Aiden, and he said that he had decreased breath sounds on the left, skin without abrasions, no ecchymosis, no lesions and no petechia. Head was normal cephalic. No oral depression, no soft tissue swelling. Anterior fontanel bulging. What does that tell you as a doctor?

A Well, that tells you in some ways the exam is identical as to what it was in Mansfield. No evidence of any bruises, petechia, or ecchymosis. All of those mean the same thing, evidence of bruising.

On the other hand, it's significantly difficult because the fontanel is not bulging at Mansfield, and by the time he got to the emergency room, then he has a bulging fontanel. And I can't be absolutely sure, but I suspect that they looked for evidence of bruising or marks or something on Baby Aiden's outside, especially on his head if they were concerned about his head. And they made particular note, and I don't believe that they would make that note in Mansfield, or I don't believe they would make that note, the transferring doctor, as no bulging and no evidence of bruising and swelling on the head unless it was so. Yet when he got to the emergency

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room, it shows that the fontanel is full and bulging. Something probably happened between Mansfield emergency room and the emergency room in Akron.

I'm not here to be critical of those people. They were doing it as good as they knew how to do it. But I am here to figure out what happened, and Aiden's problem happened a long time before March 15th, his major problem. And then something happened before he got to the emergency room at Akron Children's Hospital, and exactly when or what, I can't tell you. I'm very concerned about the endotracheal tube being too low and impeding the venous drainage and backing up into cerebral vessels, backing up into the retinal vessels, as to what happened to him.

Q Are you able to measure the amount of the old subdural bleed versus the new bleed?

A Well, what you can do is this, you can see that on all of these slices there isn't any evidence of anything new so far as the subdural space. You start to see a little bit here in the interhemispheric space. And it isn't until you get way up here on top, and the top of the skull is much smaller than it is. So you put all that together, if I were very conservative, I would say that 90 percent of the

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subdural collection of fluid is old. If I were more like I really think it is, I would say that probably 95 percent of the subdural collection of fluid is old and that's been there for longer than a month.

This new and this is -- you got to know that it's on the surface of the brain and it spreads out. Relatively speaking, it's small. It's significant, you can't have anything inside the head that's not significant. So I'm not saying it's not significant. It's relatively small and it's new bleeding that occurred prior to this being done, which was being done on March 15th in the afternoon sometime. It was prior to that. Whether it was an hour before, or two hours before, or three hours before, or even further, a day before, a week before, there is no way to tell. But it's pretty bright, which makes it pretty recent. As soon as it's there, you know, the body is always trying to clean it up as well as it can.

One of the things that we have going on in all of us all the time, which gives us a better shot at it than the automobile mechanic has, that as soon as something goes wrong with the body, the healing process begins. And the healing process has to do with circulation. It heals faster where there is good circulation as to where there is not so good.

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The healing process goes on.

So any time something happens, the healing is going on immediately when there is circulation. And sometimes something happens that is a little leak, and the body is trying to do that, and then you get more leak. So, anyway, it's recent, but it's five, at the very most, ten percent. You got to know that it's all around and then how do you estimate, very difficult to do, but I would say the new is, at the most, five or ten percent.

Q And the new blood, we can't determine how many days or how many hours before it would show up on the film?

A No. All you can do is say it's there before the film is taken.

Q Now, they also performed a skeletal survey on the 22nd of March. Are you familiar with those films?

A I am. And one of the things about the skeletal survey, and I will go back to this one for just a minute, because we didn't pay attention to this chest x-ray. But you get somewhat of a skeletal survey already here, because you've got to look at every one of the ribs, and there is no fracture. There is no evidence of new fracture, there is no evidence of old fracture.

In the old days when we first started to identify what is called child abuse or battered child syndrome, that kind of thing, we would find fractures of the ribs. And then here, you see the right humerus, you see the left humerus, there is no fracture here. So that's the beginning of a skeletal survey.

Now, we have a certain number of views that we do in the skeletal survey. They were developed before we had nice things like CAT Scans. But the CAT Scan is the skeletal survey of the head, and there was no fracture on the CAT Scan. But, yeah, those films are here. I think they are underneath that envelope, where they did -- I could only find two of them.

It's always amazing to me why --

MR. CASTOR: Object, Your Honor. There's no question before the witness.

THE COURT: Sustained.

A Why people don't bring all three of them. In my pack I have all three. But they are just plain, straight films of the head. And one of the things that you can see is you can see how wide the fontanel is there, indicating that the head has separated.

Q Doctor, first of all, tell us what exhibit number you

are referring to, and the date that was taken and time.

A I apologize. It's Exhibit 25-A and it's March the 22nd. And it's part of the skeletal survey.

Q Go ahead and tell us what it shows again.

A Yeah. Again, fontanel widely separated, increased intracranial pressure. I believe that what has been called a fracture has to do with this line here. And you can see that line on this film.

Now, I can understand how the radiologist would call that a fracture, but he has to put it all together. He has to identify that there is no swelling of the head. If you are going to have a fracture on that part of the head, you've got to have something that hit it or bruised it some time or another. And so there is no bruising. There is no swelling there. There is no bleeding on the CAT Scan that you can see, and it would show up.

But, furthermore, there is an abnormality of development of the bone of a fair number of people. And we use the term anomaly, that means it isn't quite like it is in everybody else, but this is an anomalous parietal suture. It's in the middle of the suture. It's a common place for it. Fractures ordinarily are straighter than that. This is kind of

curved and irregular, and it's a suture. And if somebody wants to call it a fracture, I can understand that, but if we saw this, and we don't get these films anymore, but if somebody did, what the radiologist would suggest is to do a CAT Scan. They did a CAT Scan on this particular day and showed no fracture. On March 15th, eight days before, showed no fracture.

So to call that a fracture, I understand how they would call it, but then they would go to the CAT Scan and show no fracture. They would go to the clinical record. And if, by chance, he truly has a fracture on March 22nd, and he didn't have one on March 15th, I'd have to ask how that happened.

And the reason they don't get these films on March 15th is because we know they aren't very helpful compared to our nice sophisticated CAT Scans. MRIs are very helpful, too, but they are a little more difficult to do, but the CAT Scan, we can get relatively easy.

I might mention also, while I'm thinking about it, because of the separation of the fontanel, when I went to Akron Children's Hospital, I tried to find his head circumference when he was admitted to the hospital. They didn't measure his head

circumference. His head circumference wasn't measured until two days later. And, yes, it was bigger than it was two months before, even further off the scale of normalcy, but by that time, he had already had operations on his head and other things. But the doctor who was helping me hunt for it, I think was a bit embarrassed also that they didn't have a head circumference on the admission.

No head circumference at Akron Children's Hospital, no head circumference at Mansfield. It would be very helpful to have that head circumference right when he got into Mansfield emergency room, or somewhere along the way. But they didn't measure it until two days after he was at Akron Children's.

Q Let's talk about what they call Shaken Baby Syndrome. I understand it's an accepted medical theory?

A Well, not accepted by everybody. What occurred, and I can give you a bit of a history because there are certain key things that occurred in the development of this problem.

Dr. Caffey was a radiologist, very famous, and when I studied pediatrics, often times Caffey's book was referred to. So he was renowned, and he came up with the term whiplash injury. That was seen in children who had multiple fractures, had multiple

evidence of injury, and they would come up with this thing of the fractures in the subdural.

Well, then over time, Dr. Kempe got involved, and I was in Colorado where Dr. Kempe was the professor, and everybody started following this, it seemed to me they were all following this whiplash injury. And so it started there, but it always had evidence of abuse, you know, cigarette burns on the child, multiple fractures, old fractures, new fractures, that kind of thing, repeated injury, and that was battered child syndrome.

Well, then they decided, well, they all aren't battered. So somewhere in there they came up with this term Shaken Baby Syndrome. Well, and they make that diagnosis when they see subdural collection of fluid, hemorrhages in the eye, and then they say Shaken Baby.

Well, this is not the proper way in a sense that on the label it says what's the cause, where, in fact, there are multiple causes of subdural. There's multiple causes of hemorrhages in the eye. And to call it Shaken Baby is clearly wrong.

Now, what is occurring in modern literature is that they are showing that there was something wrong. That Shaken Baby -- yes, children are abused,

and I am very much opposed to that, and I'm not for that in any form or fashion. But what happened is that the term started to get used, and now they use it loosely. And just because, you know, when they say Shaken Baby, they are not saying that the baby was shaken, in fact, that they have fact; what they are saying is subdural collection of fluid, retinal hemorrhages, and then, of course, anyone who quits breathing or has trouble has the possibility of lack of oxygen to the brain, or lack of circulation to the brain, and they put that together and call it Shaken Baby Syndrome.

There is little or no science -- I really think there is no science, but to give a little room -- there is little or no science to what is called Shaken Baby Syndrome.

People have done things like shaken, not really shaken, but done things to monkeys, several years ago, and other animals. Obviously you can't do that to human beings, thank God. But unless -- if it's just a sharp acceleration, you can't get the problem. Impact has to be there if that's going to be involved, so it has to hit something.

You can understand that, I think, if you can realize that even if you can imagine how someone

would shake a baby, and I can't imagine too much, the head can only move so far. And even if the brain -- it can only move so far. You can only get so much speed on it, and then it has to come back. You can get the significance of that if someone would jump out of an airplane and their parachute didn't open, they would fall at a certain rate, but nothing would happen to their brain until they hit the ground.

So it's when it gets stopped, it's acceleration, whether it be acceleration or deceleration, and that's what happens if somebody is in an accident and hit their head, or whatever else it is. It's not the fall that makes somebody get the injury to the brain, it's the stoppage that makes it.

But just shaking itself, it's very difficult for me to imagine any kind of injury like this without injury to the neck. They look very carefully trying to find injury to the neck in Aiden, on the skeletal survey, and then they did either ultrasound or x-ray, whatever they did, no injury to his neck.

Well, if you can imagine Aiden's head, and it was bigger than normal, bigger than normal, and if you can imagine it moving, where is the pressure going to be? It's going to be on his neck. So how can someone even imagine this thing happening from

shaking? I have a hard time.

And when I went to see Aiden, just so you know, I went because they asked me to see him because they wanted to stop the treatment on Aiden.

MR. CASTOR: Objection, move to strike.

THE COURT: Sustained. Folks, this is not about terminating life support. This is about whether the harm done to this baby, whether this was caused by the defendant. That's the only issue in this case. We've tried to stay away from that issue, and both attorneys know the limits.

THE WITNESS: Your Honor, I apologize. It's my fault. It's not any of them. I was trying to express why I went there. And that's the reason, I didn't go there for any other reason. Then once I got involved, then my question was what happened, and so that's how I got where I am, but I apologize, and I did not mean anything --

THE COURT: Again, Dr. Byrne, I'm not finding fault with you, or the reason you went. What I'm trying to tell you here is that we're concentrating on what the condition is of the baby, and whether the defendant is the one who caused that.

THE WITNESS: Correct, and it's my fault, I apologize.

THE COURT: Thank you.

Q Doctor, Dr. Steiner looked at his records and determined that he thinks he has Shaken Baby Syndrome. He said he determined that by ruling out other causes of his condition.

Can you tell us what other causes could cause Baby Aiden's condition?

A Well, things that cause subdural collection of fluid, birth is one of the causes, and it's the cause in Baby Aiden's case, but it could be trauma from anything.

Infection causes it. I have seen many babies as they recover from meningitis, and that kind of thing, that they get a subdural collection of fluid as part of that illness. So the ones that I have seen it in have been very certain. I didn't get any indication that he was that sick. But, on the other hand, there can be other causes of subdural collection of fluid other than whatever Dr. Steiner says there.

Q He also links up the Shaken Baby Syndrome with the fact that he thinks he has a skull fracture here. You are saying there is no skull fracture?

A Yes. I don't think, you know, that you can call that a skull fracture. That's an anomalous parietal bone.

And it happens, we go through this all the time in children, when we work in the emergency room. I worked in the emergency room for at least a good number of time in my life. And you get the skull films, and the question is, is that a fracture? Well, you go feel the head, you know, if you think there is something there, you go feel the head. If there is no swelling, you get somewhat convinced. It's not absolute, but in modern time we don't have that. We've got CAT Scans, and it gives you good pictures. There is no evidence of fracture on the CAT Scan, as they indicated in their report.

Q Is Shaken Baby the only thing that can cause retinal hemorrhages?

A I'm sorry, sir.

Q Can retinal hemorrhages only be caused by Shaken Baby?

A Oh, no. There's a lot of causes of retinal hemorrhages. The common cause of retinal hemorrhage that you see is hypertension. And people with hypertension -- diabetes causes retinal hemorrhages. So other things -- the eye is made such that it's pretty well protected. And so if you have hemorrhages in the eye, what you are seeing is a reflection of what is in the brain. And if hypertension is in the eye causing the hemorrhages, the hypertension is in the brain, too. And there are all kinds of hemorrhages, and there is no characteristic hemorrhage that means that the baby was shaken.

Q Can blood disorders cause retinal hemorrhage?

A Blood?

Q Disorders.

A Yes. Clotting disorders can do it.

Q How about leukemia?

A Leukemia can do it. The leukemia, and for six years of my life I took care of children with leukemia tumors, and I always looked in their eyes every time I saw them, looking for manifestations of hemorrhage or leukemia.

Q And I think you also said diabetes?

A Diabetes can do it.

Q How about vaccinations?

A Vaccination gets involved in this thing, and actually what happened to Aiden is that he choked and quit breathing. Well, the vaccinations get involved because babies do get swelling of their brain, and they do have abnormalities that happen and make them not function normally.

Q And in Baby Aiden's case, could a change in the

venous pressure cause it?

A Yes.

Q And where do the changes in the venous pressure, from your study of his medical history, come from?

A The changes in venous pressure happen with chest compression, with resuscitation. Actually when we even just breathe for a baby, we go differently -- you know, we, as physicians, do it differently from the way we normally breathe. The way we get air in is we make a negative pressure and air goes in. When we breathe for a patient, we make the pressure and it's a positive pressure and it pushes the air in. So whenever we are breathing for the baby, we are changing the dynamics of the circulation. Then if you put the endotracheal tube down too far, it changes the dynamics a lot. So the baby is set up to have abnormal venous return from the resuscitation, ventilation, and improper placement of the endotracheal tube.

Q Dr. Olson, the pediatrician who testified earlier in the case, said he thought he might possibly have had a ventricle blockage and that might have caused the venous pressure problem as well. Could that be the case there?

THE COURT: A what blockage?

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MR. BOGGS: Ventricle blockage.
THE COURT: Ventricle?
MR. BOGGS: Yes.
THE COURT: Thank you.

A The ventricle blockage would cause the head to get big, but the ventricles would be big. And I showed you the ventricles, they appear to be normal. It would be back when he is one month of age and his head is too big, that's part of the differential diagnosis. You look at the CAT Scan to look for hydrocephalous, which would be the increase in that. And, yes, if you had that, you could get the hemorrhages in the eye. Anything that will increase intracranial pressure makes hemorrhages in the eyes.

Q When he is having the build up of subdural fluid, how much space does he have that to collect in there before he runs out of room?

A Okay. He doesn't have any space. That's the first thing. But what happens is that the baby's head, the sutures are there, and it can expand. Whereas if we would get a subdural collection of fluid, we would have a headache, and we would be complaining, and that kind of thing, because there isn't any room in our head either for subdural collection fluid. They happen, to older people, however old that is. They

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happen sometimes, and there isn't much room.

The little baby, though, like Aiden, Aiden's head expanded. That's the reason that his head increased an inch at birth, and then another inch by three months because the sutures can spread. But it's an acute subdural that was not diagnosed. And it was there before he was a month of age, and with his difficulties at birth, I would say it was there at birth.

When I am saying that, I'm not trying to be critical with anybody. I'm trying to figure out what happened. And what happened was he had trouble with being born, a lot of people do. Then his head got too big. It was too big at one month of age, and it was still too big at five months.

Q Are you familiar with the medications that Aiden is currently on?

A Yes. I am familiar somewhat.

Q I believe he takes, what, eight milligrams of Valium a day?

A Of Valium?

Q Uh huh.

MR. CASTOR: I'm going to object. I don't know what the relevance of this is.

THE COURT: Can you come and explain

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the relevance to me, otherwise I will sustain the objection on relevance.

THEREUPON, the following bench conference began.

MR. BOGGS: Dr. Steiner said that the child was in a permanent vegetative stated. He also said that the child is not going to recover from that vegetative state. I think Dr. Malhotra and Lowcastro said the same thing. The jury saw the videotape. I think my doctor is going to tell you he's not in a permanent vegetative state. Part of his condition is he's being over medicated, and that explains a lot of his interaction or actions on the tape. I don't want the jury to think he's --

THE COURT: Is that what they testified to?

MS. COUCH-PAGE: No, they never testified to that.

THE COURT: I don't remember them saying that.

MR. BOGGS: It's in the record in there.

THE COURT: The problem with the medical records, it has not been introduced as an issue in this case. I don't think we need to get

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into that. The only reason anybody knows what his current condition is, is because you introduced the tape. I don't think you get to use that.

MR. BOGGS: So if I ask him the question would he say Aiden, is he in a chronic vegetative state --

THE COURT: That's not an issue in the case. No one is saying the serious physical harm is a permanent vegetative state. We're only saying, based on what happened to him, up to the time of the injury, the diagnosis and treatment.

MR. BOGGS: I guess what I am trying to say, his condition has nothing to do with any injury. It's a medical condition he has from birth. And if he's in a permanent vegetative state, it was not something done by my client.

THE COURT: Let me say this, why don't you ask him whatever his current condition is, was it caused by assault, however you want to say it. You don't have to spin out the vegetative state.

MR. BOGGS: The other day we were talking about the mother, and she was talking about the medications, you said that I could ask him about the medications.

THE COURT: I said if it was

appropriate, if it was relevant, you could ask him about it because he would know what they are used for. I'm not convinced they are relevant. Your defense is he's not -- if your client didn't do it, it's a birth condition.

MR. BOGGS: Okay.

THEREUPON, the bench conference concluded.

THE COURT: The objection is sustained.

BY MR. BOGGS:

Q Dr. Byrne, what would you describe or state as the medical diagnosis of Aiden's current medical condition?

A Well, I haven't gotten any official reports since the time that I visited, when I examined him, which was about three weeks after he was admitted to Akron Children's. But I did go to see him, and he's on a -- still getting ventilatory support, although when I saw him he was breathing on his own, and he still breathes on his own. The ventilator is used to be hopefully helpful to him. He's grown. He was about fifteen pounds when I first saw him. Now, he's more --

MR. CASTOR: Your Honor, I believe this is not responsive to the question.

THE COURT: Well, I think the

question -- you want to ask him about the etiology of his condition, the cause of his condition, rather than having him describe in detail what he saw recently.

Q Well, I will ask him, what is his condition today?

MR. CASTOR: Object.

THE COURT: Sustained.

Q Do you have an opinion, Doctor, within a reasonable degree of medical certainty, as to what caused Aiden's condition as you saw him?

A Yes.

Q What is that?

A What caused Aiden's condition was subdural hematoma that occurred at birth, and this was a chronic condition. And on March the 15th he already had that existing condition, for whatever reason he coughed, gagged, had difficulty with taking the bottle, and difficulty with breathing, and then came to where he is now. But his condition is a chronic subdural preexisting condition before March 15th, and then the acute bleeding, which is significant, but relatively minor in his whole condition.

Q So whoever would have been watching Aiden on that morning, around 9:30, 10:30, whoever was in his possession, watching him at that time, would be the

one sitting in Matt's shoes, is that correct?

Wouldn't matter who it was, he's going to be in the same boat?

A Correct. And you mentioned earlier about somebody else watching him the night before. It could have happened the night before, too, or the day before or the week before.

Q And there is no way you can put a time on when this new bleed started?

A The new bleed is recent. The only thing I will say is that it was there at the time they did the CAT Scan, and it's new, and you go back from that, minutes, hours, but once you start getting into days, it's beyond what it is because the body is healing it, and what is white is the new bleed, becomes more gray, more like the density of the brain. And if it's there longer than three to four weeks, it becomes black like the -- blacker like the chronic subdural that he had.

So the new bleed is there before the time of the CAT Scan. There is no way to know whether it was fifteen minutes or an hour, other than the fact that you always like to think good things about people in medicine. You like to think it doesn't have anything to do with that.

Q Another way of putting it, Aiden is --

THEREUPON, the Reporter cautioned Mr. Boggs to slow down and repeat the question.

Q Aiden is basically a ticking time bomb, he can start the new bleeds at any time without anything being done to him?

MR. CASTOR: Objection.

THE COURT: Overruled.

Q Is that correct?

A Correct. He had the condition all the time, which made him prone to doing things like vomiting. It's amazing how little kids can adjust and how parents can adjust sometimes to what is going on in their little child. So, sure, his condition, his acute condition could have occurred any time after birth. And somehow or another, he and everybody else was adjusting to the subdural when he was already -- when he was only a month of age, and they kept on adjusting until eventually something got worse and now he gets bad enough that he ends up in the hospital and gets hooked up.

Q So if I was the one that was watching Aiden that morning when it happened, I would be the one facing charges, wouldn't I?

MR. CASTOR: Object.

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THE COURT: The objection is sustained. He's going to ask another question.

Q Dr. Byrne, whoever would have been watching him on March 15th between 9:30 and 10:30, would be possibly sitting in the chair of Mr. Stein right now?

A Correct.

Q Is there any way it could have been prevented, this last bleed by Aiden?

A Well, I would say yes to that. In the sense that when he had the problem at a month of age is when he should have been worked up and evaluated. And then I showed you that picture of the little baby with the fontanel, and you can get between the bones and just use a needle and drain it off, it's very easy to do when they are tiny little babies. And that's all you have to do. You do that, they get cured. You drain it off, and then it accumulates. You come back the next day and you drain off more, you keep getting less and less until it isn't there. If you do it like that, the brain gets in the right place, the coverings get in the right place and the problem gets over with.

And, I suspect, as strongly as I can suspect, that if that would have occurred at one month of age, Aiden's problem would have been done and cured.

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Q Dr. Pope and, I believe, Dr. Olson testified that had they saw the chart on his head circumference, and assuming it was accurate on November 24th, they would have had concern and ordered the tests you are talking about, and performed the procedure that you are talking about, that you are saying, within a reasonable degree of medical certainty, Aiden might be fine today?

A Yes.

MR. BOGGS: That's all, Your Honor.

THE COURT: Okay. Mr. Castor?

MR. CASTOR: Good morning, Dr. Byrne. My name is Bob Castor. I sometimes have a tendency to drop my voice. If I do that, and you have a problem hearing me, please tell me.

THE WITNESS: Yes.

CROSS EXAMINATION OF DR. PAUL BYRNE

BY MR. CASTOR:

Q You testified that you are a clinical professor of pediatrics at the Medical University of Ohio?

A Correct.

Q Can you describe what that position is?

A Well, it's an academic appointment for teaching, and teaching medical students, residents, you know, fellow positions, is what that is.

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Q Isn't it true that your position is a volunteer position, it's not full-time, not tenured track?

A That's correct.

Q And your performance is not reviewed by your department chairman?

A Well, no, I think it's not reviewed for tenure or salary, that's correct, but I strongly suspect that I would not be able to get by with too many things that would not be acceptable.

Q You have testified here, and I believe you've testified before in the probate court in Akron --

MR. CASTOR: If I may, Your Honor.

Q Here's a copy of the transcript of your testimony, in Akron, and direct your attention to Page 183, Line 12.

You stated: First of all, the term Shaken Baby Syndrome is a term that is really not based on science as far as any new admission to the hospital. Is that correct?

A That's correct.

Q And that's still your opinion, I assume, based on what you've testified to here today?

A Correct.

Q Are you aware that the curriculum at your medical school includes understanding the epidemiology,

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presentation, workup and outcomes of Shaken Baby Syndrome for residents?

A I'm not aware of that, but perhaps you want to make me aware of it.

Q If I were to show you a page that I would submit that has been printed off the Internet, and direct your attention to the star that has been placed there. Can you read --

A Yes, it's kind of in between, but I will read both of them. The identification, management and referral of infants and children who may present to pediatrician with possible abusive head trauma or Shaken Baby Syndrome --

Q That's fine. So you agree that teaching about Shaken Baby Syndrome is part of the curriculum at your own medical school?

A I agree with that. And I agree that one of the essential components of a teacher is to teach the truth, and the up-to-date information. And the up-to-date information about Shaken Baby Syndrome is that the science has been called into question, and biomechanical people are involved, and they are coming to the conclusion that this is a misnomer in many cases.

Q So your own medical school is teaching something that

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is not based in science?
A Well, I don't know about that. I'm just telling you the way that I think the teaching ought to be done. I'm not in those classrooms when they teach about it. But there is a good chance that they teach the truth about it, at least I hope they do.
Q Do you agree or disagree that Aiden suffered serious physical harm on March 15, 2004, the day he was hospitalized?
A I'm not sure that I follow your question. But then if you want to pursue that, I have already pointed out the difference in his fontanel between Mansfield emergency room and Akron Children's emergency room, so if you are going to ask such a question, I encourage you to narrow it down to a time --
Q Prior to his admission to MedCentral Hospital in Mansfield, do you agree that Aiden had suffered serious physical harm?
A The answer to that, no, but I need to know what you mean by serious physical harm. If you mean that he choked and stopped breathing, and you are going to call that serious physical harm, then I would have to say yes. If you are going to try to say that serious physical harm meant doing something to Aiden to make him like that, I see no evidence that that occurred.

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Q Well, okay. Tell us then, in your opinion, how sick Aiden was when he got to MedCentral Hospital?
A Oh, when he got there, he had previously gagged and choked, and was resuscitated by his father and the neighbor, and then arrived in Mansfield Hospital. And there, he was such that at that time he was able to react to keep them from intubating, was still like that at that time, and then after that he got to Akron Children's Hospital, but his condition changed greatly between the admission to Mansfield --
Q I'm just asking you up to his admission at Mansfield, at MedCentral Hospital.
A I'm sorry, sir?
Q I'm just asking you to talk about his condition up to his arrival at MedCentral?
A At MedCentral, Mansfield Hospital?
Q Yes. Now, you testified that he fought off being intubated at MedCentral?
A That's what it says in the record.
Q I will show you State's Exhibit 16-E, and ask you if you can -- if you would show me in that record where it says that Aiden was fighting off the intubation?
A It says: At this time I did decide to electively intubate the patient. However, when I went to take a look the patient had a good, strong gag reflex, arms

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came up and he gagged, but this was not enough to get the patient breathing better. We continued bagging this patient. I did treat the patient with Atropine, Norcuron, which is a paralyzing agent, Succinylcholine, and also they used Ativan.
Q Okay. Arms came up and he gagged?
A Yes.
Q That's what you are interpreting as fighting off?
A Well, that's what's on this part of the record, but there's more to the record than that.
Q Where is it? Would you point it out to us, please?
A Oh, that's all that's here. The whole emergency room record is not here.
Q But that's all that Dr. Midkiff indicated in that portion of the record?
A Yes.
Q And if Dr. Midkiff testified here that that's all that happened, then apparently he left out part of what happened, right?
A That's what you said, so.
Q I don't know. I'm asking you.
Okay. It's my understanding that it is your position that Shaken Baby Syndrome can't happen without additional evidence of trauma, such as bruises, broken bones, that sort of thing, is that

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correct?
A Certainly it would be unlikely for that to occur.
Q Are you familiar with the book Nelson's Textbook of Pediatrics?
A Yes.
Q If I were to read you -- I'm going to read you a portion of that, and tell me whether you agree or not.
It says: Although grab marks or metaphysial fractures and rib fractures have been described in association with shaking, parenthesis, acceleration/deceleration, closed parenthesis, and slamming the head against an object, there may be no external marks or fractures.
Isn't that different than what you said your position is?
A I don't know that it's necessarily different, but it's what it says there.
Q You disagree with that?
A Well, I think that if you are going to be observing subdural collectional fluid and hemorrhages in the eyes, then it's improper to conclude shaking under those circumstances.
Q It goes on to say: Retinal hemorrhages are seen in 85 percent of patients who are shaken. Do you

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disagree with that?
A I would think that it would go along with the same thing. If you come to an improper conclusion and you put an improper name on it, then everything will stem from there. I'm not sure of the date of that textbook of pediatrics.
Q If I were to say it was 2004?
A Yeah, that would be that date, and textbooks are always behind the literature. But 2004 literature certainly calls into question those things.
Q And while we're at it, I believe you mentioned that CPR, is the actual name for that cardiopulmonary resuscitation?
A Correct.
Q Frequently causes subdural, or, excuse me, retinal hemorrhages?
A I don't know that you can put the term frequently, but you can certainly put the term that it causes it.
Q Again, referring to retinal hemorrhages, the very next sentence in the textbook: They occur commonly with normal birth, and rarely with -- and I may pronounce this wrong, I apologize if I do -- coagulopathies, blood dyscrasias, meningitis, endocarditis, severe hypertension, cardiopulmonary resuscitation, or impact trauma.

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Do you agree or disagree with that statement?
A Well, I have no reason to disagree, but what it says there is they do occur. And if you want to use the term rarely, as that author does, then that's what his experience is.
Q You disagree with that, then? Do you disagree -- do you disagree with him?
A Coagulopathy? I've seen many patients with coagulopathy that have hemorrhages in their eyes. That happens. Anybody that knows patients who are on anticoagulants, the fact of the matter is some of us take aspirin, they bleed more easily. Well, if you have somebody who has a coagulopathy, you can get hemorrhages in the eyes or anyplace.
Q So even though the book say rarely this doesn't occur?
A But the book doesn't say it never occurs, it says rarely.
Q Is it fair to say then that apparently it's rare that Aiden had retinal hemorrhages in association with subdural hematomas?
A I don't know about that. We do know -- we do know that Aiden has a chronic subdural. We do know that the acute problem by the time he got to Akron Children's Hospital has something more acute, and

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they've said that he has retinal hemorrhages, but we don't have a picture of them. That's as far as we can go.
Q While we're on that topic, I'm showing you what has been marked for identification as State's Exhibit 16-G, medical records from Akron Children's. You have reviewed these before, is that correct?
A Well, assuming they are what I reviewed, yes.
Q Have you seen that page that I have opened?
A Yes.
Q And what is shown on that page?
A This is a consult sheet from the ophthalmologist.
Q Okay. And can you tell actually how many ophthalmologists were involved in that consult from reading that sheet?
A Well, I can't really -- I can't even tell who was involved. There's a signature here that is somebody, and then there is another signature here that is somebody. I can tell it's 3/15. 1915 is the time, I can tell that.
Q If I were to tell you that there has been previous testimony by Dr. Lowcastro, an ophthalmologist from Akron Children's Hospital, that that was -- that record was created initially by a resident on the date and time you have indicated, and then reviewed

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by him the following day, and both of them actually observed the eyes. And, further, that Dr. Malhotra looked at the eyes, and they all saw what is drawn on there, as far as retinal hemorrhaging in the eyes, would you have any reason to disagree that that drawing is accurate?
A Well, I have no reason to disagree, but, on the other hand, it's not exactly a picture of what is there. It's some kind of a sketch.
Q Do you understand, based on your training and all the years of experience that you've had, what the drawing shows or is intended to show?
A Yes. It shows pre-retinal hemorrhage. It's labeled as that.
Q Pretty significant retinal hemorrhages, is that fair to say?
A I think every retinal hemorrhage is significant.
Q Do you have any reason to disbelieve that that's accurate?
A No.
Q There has also been testimony that, in fact, there was only one time where photographs ordered of the retina by the doctors at Akron Children's. You indicated that you thought that it had been ordered twice?

A Well, on the chart it indicates that they were taken twice.
Q The chart -- do you have that with you?
A No, but we could easily find it, because it does exist.
Q According to Dr. Lowcastro and Dr. Steiner, it was actually ordered once, that the other order was, in fact, for just pictures of Aiden rather than retinal photographs. Would you dispute that if they testified to that?
A No, but I have no reason to dispute any of that. But I just have to wonder why we don't have these things, whether they are taken once or twice. The issue is if they were taken, why don't we have them? Where are they? Why don't they exist?
Q There has been testimony that the photographs didn't come out. Don't things like that happen sometimes, even in hospitals?
A Well, let's put it this way, when I went to the photography department, they didn't tell me that they didn't come out. They told me they couldn't find them that day.
Q Well, and if later examination, investigation determined that the reason they couldn't find them was because they didn't come out, would you disagree

with that?
A I would have to accept that.
Q Doctor, how many Shaken Baby cases have you actually been involved with?
A Oh, over the years, I have seen, oh -- and I have to back off of Shaken Baby, the child abuse thing, because I have to tell you maybe ten on child abuse, suspected child abuse.
Q And possibly less than ten?
A It could be less than ten. I don't think it's anymore than ten. They asked me the same thing in probate court. I don't know the significance of it, but they pushed on me, I said five, and I said maybe ten, whatever. I do what I do.
Q Do you consider yourself an expert in child abuse, particularly in the Shaken Baby Syndrome area?
A Well, I see no difficulty in being an expert on identifying it, but I'm not an expert in child abuse.
Q Are you acquainted with Dr. Steiner?
A Only his name from in this case.
Q You have not met him?
A No.
Q Are you aware of his credentials as far as his background and qualifications as an expert of child abuse and Shaken Baby Syndrome?

A No.
Q Do you agree that history is very important to the diagnosis?
A Absolutely.
Q And would that apply to a diagnosis of child abuse?
A Well, I don't know about child abuse, but I do know that history is important. And every place in the chart that I have looked for the history on Aiden, it says the exact same thing. There is not any discrepancy. It says it every place where the history is recorded, the exact same thing, that he was being fed and he choked and he gagged and was resuscitated. It doesn't say anything else. I have no reason to do anything except say if the same story keeps getting repeated in multiple places, especially in those first few days, I would pay attention to it.
Q If I were to tell you that -- withdraw that. You then read, I take it, Dr. Steiner's report?
A Yes.
Q And his opinion that this was incidents of Shaken Baby Syndrome?
A Now, hang on, I've got to back off just a little bit. I'm not sure, is there more than one report? Is there only one report, or whatever it is? I read Dr. Steiner's note when -- shortly after Aiden was

admitted to the hospital.
Q I will show you the report that I am referring to.
A Yes.
Q If I may. It's dated March 16, 2004.
A Sure.
Q Is that what you've read?
A Yes.
Q Now, if I were to tell you that the defendant and several other witnesses have come in here and said that the history that Dr. Steiner has reported in there is wrong, that they told him something different, what would your response to that be?
A I would just have to say you have to go to the source and find out what the difference is, but I can only go by this.
Q So you accept what Dr. Steiner has reported as the history upon which you rely, is that correct?
A I have no reason to do anything except read what Dr. Steiner wrote and go from there. I was very concerned about Dr. Steiner's report within 24 hours after Aiden was admitted to the hospital. I was very --
Q Is it fair to say you were concerned with his conclusions, but not with the history that he took?
A Well, I have to accept the history. I mean, I accept

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that. I have great difficulty with him coming to these conclusions within -- within a few hours after admission to the hospital.

Q I understand you disagree with his conclusions, but for your purposes, and the diagnosis that you have made here today in response to Mr. Boggs' questions, you accepted Dr. Steiner's history?

A Sure, it's there. Whatever it is, it's there.

Q That's what you relied on?

A I paid attention to it, that's correct.

Q Now, in diagnosing child abuse, would it be important or relevant to know whether the custodian had a bad temper and a history of being rough towards the child? For example, repeatedly picking a child up like this (indicating).

A Like what?

Q Like this (indicating). Would that be important?

A Well, I would think that's an improper way to pick a child up.

Q I understand that. But would that be important in diagnosing whether or not the child was a victim of child abuse?

A Not necessarily, but it's important to teach someone who would do that that they shouldn't be picking a baby up that way. But you asked the question, and I

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assume that you have some reason to ask that question.

Q I'm asking you, you're the expert doctor. Would you take that into account in diagnosing whether or not a child has been abused particularly by Shaken Baby Syndrome?

A Well, I think that's the wrong way to pick up a baby, but I don't know that that applies to shaking.

Q If it was testified that that was done in conjunction with the defendant being mad or having a short fuse, would that be important to you?

A Well, that's not a good thing to do, neither one of those things.

Q Are you aware that 30 percent of all Shaken Baby Syndrome admissions have evidence of old subdural hematomas?

A Well, again, you focused on the Shaken Baby. I'm aware of the fact that people identify subdurals and retinal hemorrhages and then Shaken Baby. Once they label that, then, of course. But in Aiden's case, he has evidence of a chronic subdural that is one that was not diagnosed when he was born, or certainly by a month of age, and when he comes in at five months, he's going to have evidence of chronic subdural no matter what happened at five months.

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Q Isn't it true, Doctor, that subdurals that occur at birth are different than the kind of subdural hematoma that Aiden showed?

A Not that I know of, no.

Q They are smaller, more localized, and resolve -- generally resolve within three or four weeks?

A I don't know that you can say that resolve thing. Obviously anything that's big or bigger tends -- has a good possibility to be smaller at first. And certainly I would say that Aiden's subdural was not this size (indicating), but we can say that by the time his head was measured at one month when it was 16 inches, the circumference, and then it increased by three months another inch, the subdural was bigger during that time, and I suspect continued to get bigger, but his head actually, in proportion to the rest of his body, was down just a little bit, so his body was dealing with it.

A subdural, once it's there, it's not unlike a boat that has a leak in it, and has a bilge pump in it. And if it keeps leaking in, as long as the bilge pump takes it out, nothing happens. But if there is a bigger leak in, and the bilge pump can't help it, then that's what happens. And what happens with subdurals, once they are there, they continue to be

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there, yes, the body can learn how to heal it, but sometimes there is an acute event that makes for extra blood getting in there however that is, and then it gets manifest, and that's what we're dealing with.

Q Is it fair to say that what you are saying is that, as a general rule, subdurals that exist at birth, or are caused by the birth process, do not generally resolve within a matter of weeks?

A No, there isn't any label as to the time. What one does with such things is --

Q Thank you. I think you answered my question.

You have testified that in order for you to diagnose Shaken Baby Syndrome there must be trauma, or generally should be trauma with it, is that a fair statement?

A What I would say is that if you are going to say that the baby was shaken, you ought to have some indication the baby was shaken. If you are going to find subdural collection of fluid and retinal hemorrhage, what you ought to say is subdural collection of fluid and retinal hemorrhage, and approach the situation that way to find out what it is as opposed to concluding that somebody shook the baby. I don't think that's proper.

Q Would it be fair to say that in order for you to diagnose intentionally inflicted trauma on a child, which resulted in retinal hemorrhaging and subdural -- acute subdural hematomas, that there generally should be some sort of trauma associated with it?
A I would say yes, and the trauma that --
Q Isn't a skull fracture trauma?
A A skull fracture, if it's a fracture, and I've already told you, I don't believe that's a fracture --
Q So you disagree with all the doctors, including a radiologist, who have sat there and testified that Aiden did suffer from a skull fracture, and, in fact, that that skull fracture is shown on the CT Scans that you've observed? Those doctors are all wrong?
A Well, I don't know about doctors being all wrong, but I do know this much, that the CAT Scan that we showed you on March 15th was interpreted as no evidence of fracture. And that's a much better indicator of fracture than the AP and lateral of the skull, which can show that anomalous parietal suture.
Q Well, if I told you that several doctors have sat right there in that very chair last week, looked at that CAT Scan, the same one you looked at, and

pointed out to this jury the fracture of the skull that in their opinion was present on that day, you disagree with that, and it's your opinion that they are all wrong?
A Well, I don't know about they're all wrong, but I didn't see any fracture on there.
Q Is it possible they saw it and you didn't?
A Well, of course, anything is possible, but if they saw it when they were here, they didn't see it when they read it initially. They didn't see it until at least eight days after he was in Akron Children's Hospital.
MR. CASTOR: Excuse me.
THE COURT: Will you let us know when it's convenient to take our lunch break.
MR. CASTOR: Any time is fine.
THE COURT: Let's do it now then. We will come back an hour from now.
THEREUPON, there was a lunch recess.
THE COURT: Mr. Castor, you can continue your cross examination whenever you are ready.
MR. CASTOR: Thank you, Your Honor.
BY MR. CASTOR:
Q Dr. Byrne, if I understood your testimony correctly,

shortly before lunch, you indicated that, in your opinion, Aiden had no skull fracture while he was in the hospital at Akron Children's Hospital, is that correct?
A That's correct.
Q If you would, go to Page 201 of the transcript of your own testimony, starting at Line 3 and read down midway through Line 10, if you would, please. Go ahead and read it out loud.
A The first x-rays, the first CAT Scans that were done, have a whole series of pictures of that skull to look for fractures and there was no fracture. The pictures that were -- he was admitted on the 15th. The pictures that were taken on the 22nd, show some evidence of fracture.
I have to tell you that I --
Q Fine, thank you. So are you saying that the day you testified, the x-rays did show evidence of fracture that's not there now?
A No. The x-rays -- the image that's there now is the same image that was there since it was taken, but what it shows --
Q Have you changed your opinion?
A Let's put it this way, I've studied even further then I had at that time, and I can understand how the

radiologist would call this a fracture, but if you put together the clinical picture, and often radiologists do not put the clinical picture in, if you put that together, plus the fact that babies have anomalous sutures, and this is a very common place for an anomalous suture in a parietal bone to occur.
Q So you are saying you were wrong at that time?
A Well, I don't know that I was wrong --
Q And you are claiming all the rest of the doctors are wrong here?
A I don't know that I was wrong, but what I would say is that at that time I answered the question to the best of my ability, and I answered the question today to the best of my ability.
Q Even though you said then, and I quote, the pictures that were taken on the 22nd show some evidence of fracture. You are saying now that there is no evidence of fracture?
A Well --
Q Just yes or no, please.
A Yes or no.
Q Pick one, if you would.
A Well, I'm saying, yes, that's what I said then, and that was the best way I knew how to answer it then.
Q Doctor, if you would assume for me, please, that

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there was a skull fracture present before Aiden was admitted or taken to the hospital, either hospital?
A. There was?
Q. Would you assume that, please?
A. I'd have to assume something that I don't believe.
Q. Well, we frequently ask experts hypothetical questions when they are asked to assume things, so would you do that for me? Assume that prior to Aiden being taken to MedCentral Mansfield Hospital, and, in fact, prior to being taken to the neighbors where CPR was administered, he had a skull fracture, will you assume that?
A. Yes, but it's difficult for me to do that.
Q. Difficult as it may be, will you do that?
A. Okay.
Q. And base your answer to this question on that assumption.
Would there be pain felt by Aiden as a result of that skull fracture?
A. I would imagine.
Q. All right. And if there has been testimony that the evening before Aiden was taken to the hospital that he was irritable, unhappy, crying, fussy, that sort of thing, and he had the skull fracture at that time, could those attributes be attributed to the skull

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fracture?
A. Yes.
Q. So skull fracture could very well make him irritable?
A. It could, yes.
Q. Could it result, in fact, in him screaming at times?
A. Well, you keep on going with this assumption that I have difficulty with to start with, so I would accept the fact that somebody with a skull fracture could scream. I would also accept that they might not scream at all.
Q. Doctor, would you agree that there are at least three possibilities of the cause of Aiden's large head, in addition to the possibility that you have suggested, of subdural hematoma from birth?
A. I certainly agree that he's had a subdural since birth. You said three possibilities --
Q. Would you agree there are three possibilities, and I'm going to give them to you.
One would be --
THE COURT: Three possibilities for his large head size, other than the subdural hematoma you are asking?
MR. CASTOR: Yes.
THE COURT: Thank you.
MR. CASTOR: Sorry if I didn't phrase

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it.
Q. Do you understand my question? One, being genetics, his parents had a large head, or one of the parents had a large head?
A. No, not like this, no.
Q. That's not possible?
A. No, because he would have a large head at birth.
Q. Two, what about the possibility of an inaccurate measurement at birth?
A. Well, that's always possible, but my experience with nurses is that they are very conscientious how they do things in making these measurements, and so obviously any nurse can make a mistake. But if the mistake, as you are saying here, was made, then the question would be how come wasn't a similar mistake made with the weight or the length, and the weight and length stayed at the 50th percentile, and you would expect the head to stay at the 50th percentile. And it's very unusual, inappropriate to find that the head goes over the 95th percentile at one month of age when the weight and length stay the same.
Q. Isn't it true that after the baby is born, the shape of his head changes frequently?
A. Yes, it is.
Q. And that can cause the measurement to change?

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A. Usually it does not. I mean, because you still have the same content, and that's the reason that when we measure the head, this is the stable place, you can't do anything about this. Then we find the place that it's most prominent, and that's the way that heads are measured. And that will usually take into account, even though there was a difference in shape, that the head is still the same, even though it's distributed differently.
Q. The shape changes?
A. Yes.
Q. And with it -- you are saying that even though the shape changes, the size, the measurement doesn't change?
A. No, not because of the way -- it does not change, and it has to do with our method of measuring. That's why we measure that way. We have this part that doesn't change. The shape of the head can change because of shaping to the birth canal, so the nurse knows to go to the most prominent part of the occiput and measure that way. My experience is that even though the shape changes, the circumference does not change.
Q. So, again, if other doctors have testified here that it does, the circumference does change as a result of

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the changing shape of the head, they're wrong?
A Well, my goal and objective is not to say that other doctors are wrong, but I can tell you that I've measured many, many, many heads over the years, and I haven't found what you are trying to get me to acknowledge.
Q Isn't it also possible that these old subdurals are a result of abuse early on in Aiden's life?
A Well, it would have to be before a month of age, and then you would have to forget all of the difficulties around birth in that he didn't cry, and he had to be stimulated, he was pale. You've got to forget all that. I don't think it's fair or appropriate to pay attention to one thing and not put the whole thing together.
Q Doctor, while we're on the problems around birth, is it your testimony that those problems show that Aiden was suffering from a subdural hematoma immediately after birth, that those are diagnostic of the subdural hematoma?
A Well, I suspect that if you looked for it you could have found it then. But, on the other hand, Aiden's condition was such that he was in some difficulty after birth, but then he improved and got home from the hospital, and by the time he was one month of

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age, then we know his head was too big. By the time you get to five months of age, and you see these CAT Scans which shows the chronic subdural, then you have to go back and say, hey, it was there at three months, his head was too big, it was too big at one month, and he had trouble with adjusting to outside the uterus, and his birth process wasn't easy.
Q So even though Dr. Marshall testified that there really was no problems with the birth process, that the actual birthing process was very quick, only took a half hour, was she wrong, too?
A I don't know what Dr. Marshall testified to. I do know that Dr. Marshall wrote in her note that the cord was around the neck and it had to be divided, and then the baby was delivered, and those kinds of things. So, anyway, whatever is in her note is in her note.
Q What percentage of babies are delivered with nuchal cords?
A I would have to look it up to be exact. So I don't know that answer.
Q If I told you that three other doctors have testified that up to 30 percent of babies are delivered with nuchal cords, would you disagree with that?
A That seems like it's a little high to me, but I don't

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know where they got their number. Like I said, if I wanted to know the answer to that question, I would have to look that one up.
Q So you won't take their word for that either?
A Well, I didn't know I was being asked to take their word for it.
Q Well, what percentage would you say are born with nuchal cords?
A I would say that if you go percentage, I would have to look it up. It's a common thing, but we know that when the cord is around the neck and the doctor has to clamp the cord before the rest of the baby is born, at that point the baby gets no more oxygen, and the baby doesn't get oxygen then until the baby gets out.

We also know, at that point, the baby can't get anymore blood from the umbilical cord, and what happens in the birth process is that after birth the blood that's in the umbilical cord goes into the baby to conserve every place that circulation is needed, and to fill the lungs. So it adds to the stress when the umbilical cord has to be cut like that.
Q Then why don't we have a whole lot more babies suffering from subdural hematomas than we do?
A Well, the subdural hematoma doesn't come from cutting

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the umbilical cord.
Q What does that have to do with this whole case then?
A The subdural hematoma comes from the difficulty in being born, just like many babies have.
Q Dr. Marshall has testified there was no difficulty in being born. So if it doesn't have anything to do with the nuchal cord and there was no difficulty being born, where did it come from in this case?
A If Dr. Marshall said that, that's fine, then Dr. Marshall would also have to answer the question why did the baby have to be stimulated after birth? Why did the baby need oxygen? Why did the baby have difficulty with crying? Why was the baby's tone decreased? Dr. Marshall has to answer those things, too.
Q If she did say that none of those things are unusual at all in newborns, happens all the time, you think she's wrong about that, too?
A I would say that if I were a pediatrician seeing a baby and were presented with that, I would be concerned, as Dr. Olson was, and I would have to go from there.

Certainly there was something going on, and it was such that the baby stayed in the hospital for about four days. And then by one month of age the

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head was clearly too big.
Q If I were to tell you that the records actually show the baby being discharged on October 29, having been born on October 27th?
A Two days, I'm sorry.
Q So that's half of what you just based, in part, your diagnosis on, correct?
Dr. Olson diagnosed the baby from suffering from TTN?
A Yeah.
Q What is that?
A TTN, it's Transient Tachypnea of a Newborn. And what happens is that --
Q Do you agree with that diagnosis?
A I have no reason to disagree.
Q Does that have anything to do with all these things you pointed out in response to Mr. Boggs' questions that are contained in the birth records?
A Yes.
Q I assume you're also saying that it has to do with the subdural hematoma?
A Yes, they are all related.
Q Why do you suppose Dr. Olson and Dr. Marshall missed that?
A Why do I suppose -- I didn't quite hear the question, sir.

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Q Why do you suppose -- well, forget Dr. Marshall. She was not involved after the baby was born.
Why do you suppose Dr. Olson only caught the TTN and wasn't concerned about subdural hematoma?
A Well, as I alluded to a little bit earlier, babies have a limited way that they can tell you that they are in trouble. And we always, when we see the baby having trouble with breathing, we know that can be in the lungs, it can be in the heart, it can be in the brain, it can be in the kidneys. Then you have to find the cause. And the baby had retractions and had flaring of the nose, and then as the baby starts to improve outside the uterus, then they breathe fast.
It's very common that the baby in the healing process will breathe fast, meaning tachypnea, and it's transient, so we call it Transient Tachypnea of the Newborn, but it's a later manifestation of the difficulties that were going on right when the baby was first born.
Q Let me see if I understand your previous testimony correctly. Are you claiming that the retinal hemorrhages occurred while the child was on the medical flight?
A I don't believe that I claimed that, no.

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Q I'm asking.
A No. I don't believe --
Q In your opinion, when did they occur?
A They were there when they looked at them.
Q You are saying that they were not there when the child was taken to MedCentral Mansfield?
A It's every possibility that they were not there. We can't say, no one looked. But they don't have to be there at that time.
Q As a pediatrician, do you have an opinion regarding a child, less than three months, rolling over a couple of times to roll off a couch? I will expand on that by showing you the couch in particular.
If you can see that okay? State's Exhibit 1-I, the couch there. If he had testified that he laid the baby all the way against the back of the couch on his back.
A Yes.
Q And the baby was less than three months old. Do you have an opinion whether a baby could roll all the way off that couch?
A Absolutely the baby can. I've seen babies -- I saw a baby four pounds roll out of an isolette and hit the floor. I happened to be in the room. I had nothing to do with it at the time --

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Q Even if the mom said that the baby could only roll from his front to his back, he could roll all the way off that couch?
A Of course he can. That's the reason that no one should put a baby on a couch without keeping their hands or their eyes on the baby all the time. No one should put a baby on a bed, because they can always roll.
I've told you at four pounds I've seen them roll. I've seen them roll at one week. The rolling in terms of doing more things with it comes at a later age, but they can roll at any time.
Q Doctor, you have testified about all sorts of things that could have caused the retinal hemorrhagings on the morning Aiden was taken to the hospital, the bleeding that could have caused -- the bleeding in the brain that Aiden suffered from.
Can you tell us what your opinion is why Aiden stopped breathing, and heart stopped, before dad took him to the neighbors?
A This is an assumption question?
Q I'm just asking your opinion, based on everything you know at this point, would you disagree that Aiden --
A Well, I have a number of difficulties with that. This is the first time I've heard that his heart

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stopped. I haven't read that any place.
Q Okay. If I told you there was testimony to that effect, neighbor did CPR, and his heart started beating again?
A Well, I believe that. I don't know how the neighbor would know that the heart had stopped.
Q Take his pulse maybe?
A Well, I still don't know --
Q Don't people get taught that when they give the CPR lesson?
A Well, I guess I have to think differently than that. The heart is very resistant to stopping. So maybe his heart stopped, I can't tell you that it never, but I have seen babies' hearts beat for two hours without any breathing whatsoever.
The heart in young infants is very strong and resistent. Usually it doesn't stop, but maybe it did in this case.
Q Assume that it didn't stop, that he just stopped breathing?
A Just stopped breathing, and exclude all your previous things, whatever you put in there?
Q Stopped breathing.
A Assume that Aiden is at home, and he's been given the bottle, or given the bottle and he chokes and coughs

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on it, and stops breathing, that can happen.
Now, what causes him to stop breathing there, it could be the subdural itself finally gets to where it finally does affect his breathing.
Q Has the subdural then become acute, or is this still the old subdural?
A It can be the old subdural.
Q That's been bleeding for four and a half months?
A Yeah, I believe that the bleeding goes on. Remember what I told you, though, it's the chronic subdural becomes a dynamic thing. There is the acute thing with the acute blood. Then the body keeps trying to heal it --
Q Where did acute blood come from in this case? If it was the old subdural that caused him to go -- to stop breathing, to be taken to the neighbors for emergency help, taken to the hospital, was it some of his treatment givers, caregivers that caused the acute subdural after that?
A Well, the original question started out by what made him stop breathing, and we said --
Q And you said the original subdural, is that right?
A And that's correct.
Q So where did the acute subdural come from?
A Okay. So once he stops breathing, then what happens

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is that in his own coughing, vomiting, he could do it to himself.
Q That's it. Instead of being abused.
A I'm sorry, sir, what did you say?
MR. CASTOR: I withdraw that, I'm sorry, I should not have --
THE COURT: Go ahead and finish your answer. He's withdrawing his comment. Go ahead.
A Once he stops breathing, then in that process he can be trying to do things to help himself, which will increase his venous pressure and be the thing that makes it become more acute. The resuscitation itself can also do it, and then the acute bleeding, if it was there before he got to Mansfield Hospital, it was not manifest by bulging of the fontanel.
Q Wouldn't it take a while for the fontanel to start bulging once he starts breathing?
A With the acute bleeding, I doubt it. I doubt it. I think it would be there immediately as soon as you add that extra blood. So already the crowded head, I think it's there pretty quickly. That's why I am very concerned that between Mansfield Hospital and Akron Children's Hospital this condition became worse.
Well, anyway, my goal and objective is not to

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be so critical of what was done because I believe they were trying to help him. But the question is what got him to the point where he got to Akron Children's Hospital. And, yes, they can show this on the CAT Scan, the chronic subdural which is the large part, and, yes, there is the acute, but all that says is it got there before they did the examination.
Q Would I be wrong to say that, in your opinion, they may have tried to help him, but they sure screwed up?
A Oh, I don't think that's my goal and objective. I'm sorry, sir.
Q It's not your objective, but that's your opinion?
A I'm still -- my goal and objective --
Q You have previously testified, I believe, that you disagree with Shaken Baby Syndrome as a diagnosis in part because doctors jump to conclusions about it, is that a fair statement?
A I think in this case they came to conclusion far too quickly, yes, sir.
Q Even though they have now testified that they did -- ran tests and conducted examinations to exclude every other possible cause that they could all think of, including birth trauma?
A Well, I can't tell you what they can say that they excluded, but I can tell you that the records in the

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clinic clearly show that his head was too big at one month of age. The records of the hospital show that his head was not too big at birth, and that his difficulty -- he had some difficulties around birth. And while his head was too big at one month, it was still too big at three months. And when he had the trouble, that aspect of it was not looked at.

Q Is it fair to say, Doctor, the bottom line of your testimony is that the jury should believe you, who have treated less than ten Shaken Baby Syndrome babies, when you disagree with specialists in the field of child abuse and Shaken Baby Syndrome, other pediatricians, a radiologist, a trauma specialist, standard textbook on pediatrics, and you dispute the scientific basis of the curriculum of your own medical school?

A The truth is the truth, and it doesn't waver. The truth will always be the truth. And the truth is this baby had difficulty being born, his head was too big at one month of age, the CAT Scan shows a large chronic subdural that had to be there for weeks, months, before he came in the hospital, and that will always stand. It will never go away no matter what anybody says.

MR. CASTOR: Thank you. I have no

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further questions, Your Honor.

THE COURT: Your turn again, Mr. Boggs.

REDIRECT EXAMINATION OF DR. PAUL BYRNE

BY MR. BOGGS:

Q Dr. Byrne, when he asked you about the curriculum there at the medical school, don't they teach all the known theories so doctors have everything available to them when they make a diagnosis?

A Yes.

Q Kind of like we did when we had the flat earth, people saying it was round and flat, same ideas?

A Yes.

Q We haven't went back that far in the medical science, have we?

A I hope not.

Q Now, at what age did you say babies can roll?

A Well, they can roll at any age, but usually they don't roll until three, four months kind of thing. At least we don't get concerned until we get back past the four and a half months. They can roll at any age. I've seen them do it.

Q He asked you about your transcript, Page 203, I think it was.

A What page?

Q Page 203?

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A 201, I think, is where he was, but go to 203.

Q Wherever he had you, he wanted you to read something and you started to explain and then he stopped you. Can you go ahead and explain what your answer was, regarding the fracture, what you meant to say, more information at the time you gave that answer?

THE COURT: It's about the skeletal survey, whether it showed a fracture in the skull, is that what you're asking?

MR. BOGGS: Right.

A And then what I went on further to say is that, and I have to tell you that I didn't concentrate on that so much as I did the first ones, because the fracture was going to be there on the 22nd and not on the 15th, how did it happen if the baby was in the hospital the whole time?

So if somebody was saying fracture on the 22nd, and they had -- the same people were saying no fracture on the 15th by a better test, then what were they trying to do?

Q Okay.

A And I might add, sir, since that time I've tried to find a better answer, if that's the right way, but to find out how you differentiate to that line from a fracture. A fracture usually has a straighter line.

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The fracture will have swelling over it, and also there will be some bleeding in it. And this is a common place for what is called, in the literature, an anomalous parietal suture. And so I can understand how they went that route, but I think they should reconsider.

Q Okay. Now, also when you testified at the Akron proceedings, you had not had full access to all the records, a chance to review everything in its entirety and study it carefully, had you?

A That's correct. The fact of the matter is I asked for all the records, but the records about the well baby clinic and his head circumference, other than I had it at birth, but his head circumference at one month and three months and that I didn't get until after I had to give that testimony.

MR. BOGGS: That's all. Thank you, Your Honor.

THE COURT: Recross?

RECROSS EXAMINATION OF DR. PAUL BYRNE

BY MR. CASTOR:

Q You have had free access to all the records for your testimony here, have you not?

A I have had free access to what you have shown me. I have not had free access to all of the records of

Aiden. The last time I was able to get any records had to do with a few days before I testified at the probate court.

Q Well, you have had contact with Mr. Boggs, have you not, in preparation for your coming here?

A Yes.

Q Have you asked him for any records that you thought you might need in order to confirm your diagnosis?

A Well, if I had my way, I would like all of the records, but the significant -- you know, all of the records of Aiden, which I haven't been able to get any -- but the significant records have to do with what happened to Aiden prior to the CAT Scans, and I do have all those records.

MR. CASTOR: Thank you.

THE COURT: Do any of you folks have a question for Dr. Byrne? We do have a couple.

THEREUPON, the attorneys approached and read the questions posed by the jury and the following bench conference began.

THE COURT: Objection to any of them?

MR. CASTOR: No.

MR. BOGGS: No.

THEREUPON, the bench conference concluded.

THE COURT: Doctor, I have several

questions that I want to ask in addition to what's already been asked. The first have to do with meningitis.

Can you explain aseptic meningitis?

THE WITNESS: Yes. Should I explain it to you or to them?

THE COURT: To them.

THE WITNESS: Aseptic meningitis is when we do the spinal tap and we see white cells in the spinal fluid, but we don't culture a bacterial germ. And, in modern times, we do much better in culturing a virus germs that can cause that. But aseptic meningitis often is due to a virus or something else that doesn't have to do with bacterial meningitis.

THE COURT: Can you explain lymphocytic predominant meningitis?

THE WITNESS: Yes. Lymphocytic predominant meningitis would be similar. In bacterial meningitis you get probably more from nuclear leukocytes, those kind of white cells that respond to bacteria. Lymphocytes tend to respond to a virus more, and they are more slow, later coming, that kind of thing. Aseptic meningitis could also be diagnosed as lymphocytic meningitis.

THE COURT: I think the next one says

can you explain melanitis (phonetic) meningitis?

THE WITNESS: I'm not sure about melanitis. I'm not sure what that word is.

THE COURT: I'm not sure either.

THE WITNESS: It's close to melanoma. I'm not sure if that's --

THE COURT: I'm not sure what the word is either. Can anybody tell me what that word is?

THE JUROR: Mallorits (phonetic).

THE COURT: Mallorits meningitis?

THE WITNESS: I can't. Is it a man's name, a person?

THE JUROR: Mallorits meningitis, that's all I'll ask.

THE WITNESS: I don't know what it is, sir. I'm very sorry.

THE COURT: How about recandescent (phonetic) meningitis?

THE WITNESS: Maybe it comes back some way or another. I don't know. Recandescent, sometimes -- like rekindling type of thing.

THE COURT: So the two types that you recognize, at least from these terms here as they've been written, is aseptic and lymphocytic predominant?

THE WITNESS: Right.

THE COURT: In which of these cases do you see a brain bleed? Or, which of these cases can you see a brain bleeding?

THE WITNESS: Usually more likely -- well, you can see the brain bleed in any of them, as far as that goes. But the ones that are associated with the subdural hematoma tend to be more of the bacterial kind of meningitis than the aseptic ones.

THE COURT: And would you consider yourself an infectious disease specialist?

THE WITNESS: No, but I have to know a lot about infectious disease in terms of pediatricians have a lot of infections that we have to deal with, and then a neonatologist takes care of everything in the newborn. So you have to know a fair amount about infection, a fair amount about nervous system problems and the like.

THE COURT: How many babies have you seen who have been delivered and qualify as cyanotic?

THE WITNESS: I have seen a lot, yeah. Usually, you know, if it's normal, it clears up right away. It's normal for a baby to be cyanotic at birth. Inside the uterus, the oxygen that the baby is exposed to is like the oxygen in our veins. It's exposed to a venous pool, the placenta is, so the

highest oxygen before the baby is born is what's in our veins, which makes the baby blue at birth. But as soon as the baby starts to breathe, the baby gets pink, maybe not with hands and feet quite so much, but pink right away, and is crying and vigorous and a normal baby like we always hope to have.

THE COURT: The next question is: What were some of the fates of these babies? I guess it would depend on --

THE WITNESS: Oh, with cyanosis? Just general, they can get better right away, with cyanosis. And then if a baby would have persistent cyanosis, then we get into things like does the baby have congenital heart disease, does the baby have lung disease or something else. And we always think of the nervous system, so that if the baby has trouble with breathing, and we identify it's not the lungs, we identify it's not the heart, often times we will get an ultrasound of the head, and can make the diagnosis of what that problem is. But then even then, if we don't get the answer, then we think more about kidneys. Babies can be born with serious kidney problem, it gets manifest with difficulty with breathing, and that's what draws our attention.

THE COURT: Is it extremely unusual for

a newborn to be given oxygen by means of an oxygen mask?

THE WITNESS: No, it's not unusual, but it's unusual that it would persist to the point where they're even weighing the baby, they are concerned about taking that oxygen mask away. Usually by the time they are to the point of weighing the baby and measuring the length and that, they are usually pretty content. The nurse is pretty content that the baby has adjusted okay. Since people are anxious to get weight and length, they might try to get that done, but they keep the oxygen going because they're concerned, the nurse is concerned.

THE COURT: Do you have any estimate of how many babies are born with subdural hematomas? Percentage terms of the birth, perhaps.

THE WITNESS: No, I don't have a percent. All we know is that it does happen. I saw a baby not too long ago that probably has a subdural. The fluid is more clear. It makes you always wonder if it hadn't been there for a while. Then I saw a baby not too long ago that had a fracture of the skull at birth, like I told you about. We don't see too many of them. Over the years, I have seen a number of them, but we don't see too many.

THE COURT: The next question has to do with your testimony that people can live a normal life with one lung.

THE WITNESS: Yes.

THE COURT: Are they subject to a greater frequency of subdural hematoma as a result of that?

THE WITNESS: No, it's a different kind of setup by that time. If a person has the lung removed because of, say, cancer of the lung, the body adjusts and the like, and those are adults, kind of thing, so it's different.

THE COURT: Can bleeding in the brain cause high sugar levels?

THE WITNESS: I think the answer to that is yes, that, yes, the answer to that.

THE COURT: Okay. And did you want to explain the mechanism of that?

THE WITNESS: Well, it can be with the abnormal function of control, which has to do with the brain. A lot of things can go wrong, but also in a baby who could have had a good supply of sugar in the body, and then something happens to the circulation, all kinds of things can go wrong. And I think it was a concern, as evident on the record when

they were transferring the baby, that the sugar was so high, but it cleared up right away. So I am sure they were happy for that.

THE COURT: The next question is: How many cases of meningitis have you seen? And I think they mean in infants.

THE WITNESS: Oh, I have seen a lot. I've done this work for a long time. We don't see so much meningitis anymore. One of the things we do to prevent meningitis in a newborn is we give the mothers antibiotics which prevents the Group B Strep. Group B Strep is the common cause of meningitis in infants these days.

When I was a younger physician, it was Gram-negative rods/Ecoli and the like, but I have seen a fair number of babies with meningitis over the years.

THE COURT: In the babies with meningitis, how often have you seen that result in a brain bleed?

THE WITNESS: Well, you can get that. I haven't seen a brain bleed, you know. When we see the brain bleeds, the subdurals occur from the pressure at birth. The other time we see brain bleeds is in premature babies. The premature babies

are prone to having interventricular hemorrhage that occurs, but that's deeper in the brain. Down in this area (indicating) is where the prematures get theirs. Up on the surface is when the term babies, more likely vaginal deliveries, get the pressure on hemorrhage there, different kinds of hemorrhage all together.

THE COURT: How many anomalous sutures have you seen in your professional career?

THE WITNESS: Oh, I have seen a number over the years. I started the Neonatal Intensive Care Unit in Cardinal Glennon Hospital in 1963, and by the time I left there, I was getting more than six hundred babies a years, coming from more than fifty hospitals, and we saw a lot of things. Every day one of the things I did when I would get done rounding on the babies, is go with the residents and two of the radiologists and review every film. So we would see that, and the radiologist would teach us how to, if there was a fracture, the line was straighter, and would teach us to pay attention to the clinical picture. I don't know what that radiologist would say, I mean, the ones I worked with, I was certainly tempted, but I didn't know how to get hold of them, to look at that and see what they would come up with.

But what we would be taught is to say, yes, that could be a fracture. You put the whole thing together, I would say not a fracture, and in modern times, we have CAT Scans. The CAT Scan, if there is a fracture, it's better at showing the fracture. It would also show bleeding, you know, the hemorrhage at the fracture lines. Anybody who has ever had a fractured wrist or an ankle, they know immediately it swells, and there's lots of blood. Same way with the bone of the head, you know. And so I would expect, if there was a fracture there, to have bleeding on the CAT Scan if it was there before the 15th. They certainly hunted for it, and they specifically wrote no evidence of fracture. And so I was surprised when they came up later with this thing.

THE COURT: Do all doctors and health organizations use the same types of scales and graphs to figure the percentiles on head circumference, weight and height of a newborn?

THE WITNESS: Yes. The two kinds that I showed you, they both come from the same data, and you can get them on the growth.com kind of thing and look them up, and you can find those on there. The one that I showed you, those things are reproduced by the drug companies, but you can get them online, and

they are all the same, and they are put together by data.

There are different kinds of graphs, though, because one of them uses standard deviation, just a statistical thing, and then the other uses percentiles. The percentiles go from zero or two up to 98; whereas the standard deviations are a statistical thing, you get the mean and then you take one standard deviation, which is 34 percent above and 34 percent below, which makes 68 percent. Then when you go to two standard deviations, you get 95 percent in there.

So there are two different ways, but they show the same thing, but you have to know what's behind it when you look at it.

THE COURT: The juror goes on to ask whether these charts differentiate between different types of babies, is there one type for premature births, another for five to seven pound births, and possibly another for large babies. Are there different charts for each class of infant?

THE WITNESS: Yeah, we do have some differences, but that's the reason that the one that I made, it has on there about the premature babies. And you can see the angle of the curves is a little

different for prematures. But Aiden was term, so it doesn't really get into that.

THE COURT: Are you saying there is one chart for all term babies?

THE WITNESS: Pretty much so. Those statistics came from primarily, my memory says, caucasians. And there are some differences in different races and that kind of thing. But they were done by people trying to do the best they could to get the mean, and then the deviation from the mean.

THE COURT: The next question has to do with your testimony about seeing the four pound baby roll out of the isolette. They are asking how did that happen, don't isolettes have sides? How did this four pound baby roll out of the isolette?

THE WITNESS: Isolettes are made differently now from what they were before. And the way the isolette was made in the past is that the top of it would roll back. And it happened to be a nurse who was going to catheterize the baby, and she had set the basin and the catheter, it was actually on the windowsill right next to it, and then when she reached to get the catheter to insert it into the baby's bladder, the baby rolled on the floor. She

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was devastated. Nothing happened to the baby, thank God. She was so upset she quit taking care of babies, I remember her, so.

THE COURT: She quit taking your babies?

THE WITNESS: She quit taking care of babies. She quit pediatrics. She couldn't stand herself for letting it happen.

The rule is -- and I've taught many medical students and residents over the years, nurses -- the rule is any time you look at the baby, you have your hands and your eyes on the baby. If you have to take your eyes off, you hold on to an extremity, an arm or a leg, to make sure the baby doesn't fall. If you have to take your hands off, then you don't take your eyes off so that you can grab the baby quickly so the baby doesn't fall.

THE COURT: If subdural fluid would have been collecting from birth in Baby Aiden causing pressure to his brain, would his motor skills be impaired?

THE WITNESS: They could be, but not necessarily so because the body in the healing learns to compensate. And Baby Aiden did fairly good in terms of his head getting bigger, so that takes the

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pressure off. So I would expect that whatever he did he would have done better if he would have been diagnosed at one month of age. Even if he couldn't have been diagnosed right at birth, he would have done better if he would have been diagnosed then.

THE COURT: Follow-on question to that: How noticeable would any impairment be as to physical functions, such as rolling over, during the first, second or third month?

THE WITNESS: Well, it can be a problem because the head is bigger. So it makes it much more difficult for the baby to control his head. Babies who have big heads like that, often times, you know, ordinarily when a mom or caretaker picks up a baby, especially a newborn baby, they watch their head, although the neck gets pretty strong, pretty quickly. But babies who have what, we call it macrocephaly, for whatever it is, whatever the cause is, babies who have bigger heads, you have to be more careful with them because in order for them to control their heads, they have to have stronger muscles and that kind of thing. And Baby Aiden's head was too big.

THE COURT: Does counsel have any follow-on questions to those questions?

MR. CASTOR: No, sir.

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MR. BOGGS: No, sir.

THE COURT: Thank you. You can step down, Dr. Byrne.

THE WITNESS: Thank you very much, Your Honor.

THE COURT: You're welcome.

THE WITNESS: It will take me a couple minutes to gather up my --

THE COURT: We will let you do that. And we will give you back your extension cord, too.

Folks, this doctor has to get his things together, another doctor is coming in and they are going to set up some exhibits for him, so let's take a break.

THEREUPON, there was a brief recess.

THE COURT: Are you ready, Mr. Castor?

MR. CASTOR: Assuming the defense has rested, Your Honor?

THE COURT: Okay.

MR. BOGGS: We'd rest subject to our exhibits, Your Honor.

THE COURT: All right. He's rested subject to admission of the exhibits. Go ahead.

MR. CASTOR: Call Dr. Max Wiznitzer.

THE COURT: Before you sit down, I'll

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swear you in, Dr. Wiznitzer.

THEREUPON, the witness was duly sworn by the Court.

DIRECT EXAMINATION OF DR. MAX WIZNITZER

BY MR. CASTOR:

Q For the record, would you state your name, please.

A Max Wiznitzer.

Q And your business address?

A I'm at Rainbow Babies & Children's Hospital, 11100 Euclid Avenue, Cleveland, Ohio 44106.

Q What is your business profession or occupation?

A I'm a child neurologist.

Q And let me ask you a few questions about your qualifications to testify as an expert today.

What educational institutions did you attend after high school, and what degrees did you obtain?

A I attended Northwestern University. I was in the honors program in medical education, which is a six year program in which you get a Bachelor's of Science in medicine, followed by your M.D. This was done first at the Evanston Campus, for anyone who knows Illinois, followed by being done in the Chicago Campus down at the University.

Q And did you receive any additional formal medical training in hospitals?

P.A. Byrne MD
577 Bridgewater Drive
Oregon OH 43616
419-698-8844
pbyrne@toast.net

Re: Aiden Stein (DOB 10-27-03)

Dear Dr. Byrne:

I have reviewed the brain CT (3-15-04, 3-16-04, 3-17-04, 3-22-04) and skull x-rays (3-22-04) on the above child along with the clinical summary provided. The initial CT shows bilaterally large extracerebral low density collections (nonspecific subarachnoid or subdural fluid) along with some less extensive extracerebral high densities (hemorrhages or thromboses), especially high convexity frontal, left greater than right, and interhemispheric. Less obvious high densities are also present along the tentorium, dural venous sinuses, and falx. There are bilateral cerebral low densities with decreased gray-white matter differentiation (likely edema). There is prominence of the fontanelle and sutures and a question of cranial osteopenia. The parietal cranial irregularities likely represent suture variants rather than fractures. The skull radiographs show parietal cranial lucencies, likely representing accessory sutures or fissures as normal variants. The follow-up CT examinations show the presence of bilateral frontal extracerebral catheters post-surgery, increased high densities (hemorrhages), especially left extracerebral with rightward brain shift, and evolution / progression of the cerebral density abnormalities (edema to necrosis). An MRI was not done.

The CT findings of extracerebral low densities are nonspecific and may represent benign extracerebral collections of infancy or subdural collections of indeterminate content and age. Only an MRI can clarify this (in the absence of proper and timely neuropathologic analysis). The high densities represent subarachnoid and/or subdural hemorrhages. Some of the high densities may also represent venous thromboses. Again, only an MRI can clarify this. The evolving cerebral low densities likely represent edema evolving to necrosis. The findings are in no way characteristic of, or specific for, nonaccidental injury. In fact, as correlated with the clinical data, the imaging findings are consistent with long-standing extracerebral collections (e.g. benign extracerebral collections of infancy vs. chronic subdural collections) with superimposed hemorrhage (e.g. rebleed) complicated by hypoxia-ischemia. Other considerations for the imaging findings would include superimposed infection, coagulopathy, cerebral venous thrombosis, and accidental trauma, including surgical effects. My opinions in this case are expressed to a reasonable degree of medical certainty and based upon my more than 25 years of clinical, teaching, and research experience in injury to the developing brain. Please notify me at any time if I may be of further assistance.

Sincerely,

Patrick D. Barnes, MD
Chief, Pediatric Neuroradiology
Director, Pediatric CT and MRI
Lucile Packard Children's Hospital
Associate Professor of Radiology
Stanford University Medical Center
pbarnes@stanford.edu

EXHIBIT #7

AF

EXHIBIT #8

WS-186-04 STATEMENT: MATT STEIN
G.O. 8,543 (Child Abuse)
SUSPECT: MATT STEIN

BEGIN TYPING STATEMENT: 1700 hours, 3-16-04

This will be a voluntary statement reference to report number 8,543. It will be at Akron Children's Hospital. It is approximately 1920 hours. Present is myself, Detective Blust, Detective Cassidy, and Michelle Flaherty of Children Services and MATTHEW STEIN. We will be at Fourth Floor Conference Room, at Children's Hospital.

Q: Matt, can you state your name for the tape?
A: Matthew Paul Stein.
Q: And you are here voluntarily, on your own free will, to give this statement, is that correct?
A: Yes sir.
Q: There's been no promises, threats, or force used against you to get you to make this statement?
A: None, no sir.
Q: And you are aware that the Mansfield Police Department is investigating an incident involving your son, Aiden Stein?
A: Yes sir.
Q: Let us start at the beginning. Today is the 15th.
A: Do you want me to just go over it.
Q: Yeah, Erica, that's your girlfriend, is that correct?
A: That's correct.
Q: And did you wake up when she went to work today?
A: Briefly she woke me up. Sometimes I drive her in the morning, 'cause we only have one vehicle, she tried to wake me up and I was like "man, I just wanna sleep, call my mom, you know, tell her after she gets out college just come and pick me up and watch Aiden for the hour that I have to work and you have to go to work", she had to work.
Q: So you are the primary caretaker of that point, after she went..anyone else there?
A: No, nobody else was there, sir.
Q: And what time does..is this normal, that you do this about every day that Erica goes to work?
A: Oh yeah, that's why we work different shifts, 'cause we don't trust people, the day cares.
Q: What time did you wake up this morning, and how did you wake up?
A: It was between 10:00 and 10:15, it was at that time that I woke up because I heard my son in the other room crying and it was time to feed him.
Q: And what did you do?
A: I woke up, I walked into his room and checked on him, to make sure he was all right, 'cause sometimes he will pull the blankets up over his head.
Q: Was you still tired though, at this point?
A: Was I still? Oh yeah. I mean, I barely remember going in there but, so then I stumbled into the kitchen, make his bottle, got his little bassinet ready 'cause I had to go to the bathroom, it's a morning ritual.

EXHIBIT E ALL-STATE LEGAL®

Appx E

Q: Was he still in the crib at this point?
A: Yes sir. So I did that, got his little pillow, ready to prop it for him.
Q: Was he still crying while you were making the bottle?
A: Well, he cried until I got the bottle ready and then he quit crying, so that's when I went in and checked on him and I discovered the blanket was over his head.
Q: Was he laying down or standing up, or what was he doing?
A: He was laying down. He can't stand.
Q: And the blanket was over his head?
A: Yeah, well, it wasn't like over his head but it was pulled up, you know what I am saying, like he had just pulled it up, and he had fallen back asleep or something 'cause when I pulled the blanket back off of him he rolled around a little bit and then he opened his eyes and they were kind of red and bloodshot.
Q: The blanket wasn't stopping him from breathing, is that correct?
A: It shouldn't have been.
Q: And did he smile or anything at you?
A: No, and that's really funny. He didn't smile and he always smiles when he sees one of us, and so I got him out of his bed and he woke up a little bit and he started getting a little bit more playful but he just wasn't acting like his normal self, 'cause he an energetic kid and he likes to play, so I kind of just held him for a little bit and showed him his bottle and he opened up his mouth like he always does, and then I had to go to the bathroom, checked out the bassinet, you know, put it in front of the door of the apartment, the bathroom door that way I could sit and see him and I put him in there, put the pillow across his mid section right here and I sat the bottle on top of it and he started eating and he just got pissed, mad, because I had him in there and I wasn't holding him, I wasn't paying attention to him and he started screaming and I picked him up before I went to the bathroom.
Q: Did you ever leave out of sight of him at that point?
A: Just when I sat him in there before I went to the bathroom. We have connecting doors. Like we have a door here for our bathroom and we also have a door that goes into our bedroom. Both doors were open. I sat him in there and I walked around, grabbed a magazine, and went back in.
Q: But he was still in his bassinet though?
A: Yeah.
Q: He never fell or anything like that?
A: Not that I know of..not that I saw.
Q: He couldn't have because..
A: No, he can't move, I mean, he's just kind of...
Q: Is that correct?
A: Yeah.
Q: So then what happened after that point?
A: Ok, I got him out, he stopped crying, 'cause I was holding him. I said "hey, Dad's gotta go to the bathroom, you are gonna just have to deal with it". I sat him in his bassinet. He did bump his head but it wasn't..it was nothing, I

swear it was like that, and he looked right at me and he just kind of like..
Q: What did he bump his head on?
A: There is a metal bar that runs..on our bassinet there is like a metal bar that comes around it, but there is a little bit of padding over it so I didn't think it really did anything to him, didn't think anything about it until you asked me.
Q: How did he bump his head on that?
A: I was just sitting him in there and he was flailing 'cause he knew he was getting set down.
Q: So he was flailing, trying not to be sat?
A: Yeah, he knew. He knew he was going on his bassinet and eat and I was going to the bathroom. That was how it was gonna happen.
Q: So did you kind of have to force him into the bassinet?
A: No, he's a little kid, you ain't gonna have to force a little kid.
Q: Right, but he flailing around?
A: Yeah, I mean, he's flailing but it's not like you got to force him in there. You are the father, you know, you put him in there, what's he gonna do.
Q: So then what happened?
A: So then I put the pillow back over his chest. I put the bottle back on him, on the pillow, and in his mouth, and as soon as it went in there he started screaming and I could hear something like the milk was getting caught in the back of his throat or something, so I thought he was choking. I threw the bottle, I picked him up and started patting him on his back, trying to get it out. He started turning real red, got real angry, and so I grabbed his little nose sucker. I sucked the snot out of his nose, figured maybe if he could breath through his nose he would be fine, but by the time I got the nose sucker, he quit breathing. I ran and I picked..I had him in my arms, I ran to the neighbor, knocked on the one door, she didn't answer, I am yelling "help, help", turned around and knocked on the other door and she must have heard me in the hallway 'cause she was kind of opening it as soon as I was knocking and, you know, she was like 'what's wrong' and I told her what's wrong and she took Aiden from me and rushed him over to the couch and sat him on the couch and her boyfriend, I don't know the peoples names, he came in and started giving him CPR and we called 9-1-1, you know, and they got there less than five minutes, I would say.
Q: Was he dressed at that point?
A: He had his little nightie on..his little green outfit, but when they got there they took that off him, and his shoes.
Q: Did you change his outfit at any point?
A: No, 'cause I didn't even have a chance to change his diaper yet.
Q: Has he ever been injured or anything like that in the past, that you know of?
A: Yes sir. A couple of months ago, and we did take him to

WS-186-04 STATEMENT: MATT STEIN
G.O. 8,543 (Child Abuse)
SUSPECT: MATT STEIN

the emergency room..a couple of months ago he rolled off the couch..I sat him up on the couch and I was gong to make a bottle and I didn't realize he could roll like that and I sat him all the way on the end of our couch, like if you take the cushions off there is..you've got another six inches, I didn't think he was going anywhere. He rolled off and he hit his head and he had a little..he had some like..I don't know what you would call that, blood, they were kind of bloodshot but it was like a little patch, and we got concerned about it and we took him to Med-Central and we told them what happened and they said 'oh, it could be anything'. They didn't do no test or nothing and a couple..I would say about a week or so later it went away.

Q: Did he have any marks on his head, or anything like that?
A: No.
Q: Did you ride up to the hospital with him today?
A: I rode to Med-Central with him and then they life-flighted him so Erica..obviously she is lighter than I am and they said there was a weight capacity so she rode with him and I came up with my mother, her mother and my grandmother and her friend.
Q: Have you talked to any of the doctors or nurses about what the problem is with Aiden?
A: I asked them and at first they told me it was a trauma to the head and I was real, you know, curious on how that happened, and then my mom said she spoke with the doctor and she said that somebody shook him.
Q: Is that possible?
A: Not on my part, it's not.
Q: Was there anybody else around him this morning?
A: No.

I have read and/or have had read to me the above typewritten statement consisting of ____ pages of typewritten matter. Each page bears my signature, the corrections, if any, bears my initials. I swear or affirm that the contents are true and correct to the best of my knowledge.

WS-186-04 STATEMENT: MATT STEIN
G.O. 8,543 (Child Abuse)
SUSPECT: MATT STEIN

Sworn to and subscribed before me this _____day of_____ 2004.

WITNESSES:

_____

_____

_____
Notary Public

_____
My Commission Expires

Transcribed by Patsy Ballitch 547
1800 hours, 3-16-04

IN THE COURT OF COMMON PLEAS
RICHLAND COUNTY, OHIO

STATE OF OHIO)
) ss:
COUNTY OF RICHLAND)

CASE NO.: 05-CR-224D

JUDGE JAMES DEWEESE

SUPPLEMENTAL AFFIDAVIT OF SEAN BERENDT

I, Sean Berendt being first duly sworn, do hereby depose and state:

1) That I was involved with a conversation with Lindsay Smith, a juror in this case, at our mutual place of employment during the trial in which she expressed her firm opinion that the State of Ohio had no evidence upon which to convict the defefendant Matthew Stein of any crime against his son Aiden Stein;

2) Although my father immediately contacted the Court and the Prosecutors involved to complain of this juror's conduct in discussing the case outside of court during trial, the Court never contacted me nor called me to testify at any hearing regarding this fact;

Further, Affiant sayeth naught.

Sean Berendt
SEAN BERENDT

Sworn to before me, a Notary Public, and subscribed in my presence this 27th day of February, 2006.

Notary Public (No expiration date, R.C. 147.03)

EDWARD MARKOVICH, Notary Public
Residence - Summit County
State Wide Jurisdiction, Ohio
My Commission Expires RC 147.03

EXHIBIT # 9

APPX. B